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ABSTRACT

This document consists of revised editions of both a handbook for coordinators and teachers of a 75-hour nurse aide course and the nurse aide curriculum itself. The handbook's stated purpose is to assist health coordinators in community colleges and secondary health occupations instructors to offer the course. Introductory materials include overview, teacher requirements, source for course materials and tests, source of information for offering a high school program, information on teacher training, and list of approved teacher trainer trainers. Other contents include general information about testing, written/oral and skills test plans, instructions for test administration, application for test, and selected guidelines for course/competency test. The curriculum guide begins with a course description and information on teaching methods, clinical requirements, student evaluation, and credentialing. A list of competencies, criteria for assessment of student achievement, and a list of outcomes and assessment type follow. Each of six units begins with an overview that is followed by an outline that details objectives, related content, and teaching method. Topics include introduction to the role of the nurse aide; working environment; personal care of resident; nutrition; routine medical care; and care of residents with specialized problems. Thirty-three skills checklists, summary sheet of skills checklists, and clinical evaluation form are appended. (YLB)

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ED 371 134

A HANDBOOK FOR COORDINATORS AND TEACHERS OF 75 HOUR NURSE AIDE COURSE

May 1990

Program in Health Occupations Education
College of Education
The University of Iowa
North Lindquist Center
Iowa City, Iowa 52242

In Cooperation With

Division of Community Colleges
Department of Education
Des Moines, Iowa 50319

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PREFACE

The purpose of this Handbook is to assist Health Coordinators in the Community Colleges and secondary health occupations instructors to offer the revised 75 Hour Nurse Aide Course. The written and skills competency test guidelines are also included for community college coordinators. The guidelines/ materials were developed to meet criteria established in Nursing Home Reform Legislation included in recent OBRA legislation and resulting rules and regulations developed by the Iowa Department of Inspections and Appeals. The Department of Inspections and Appeals has reviewed this Handbook.

Materials and processes included in the Handbook predispose a knowledge of basic educational processes and familiarity with organizing and offering educational programs.

The Handbook is designed so coordinators/instructors can readily remove/ replace pages as criterion is revised. Current materials will be provided by Health Consultants from the Program in Health Occupations Education.

If you have any questions or suggestions as you use this Handbook, please contact Joyce Brandt (319) 335-5322.

Joyce A. Brandt, Ph.D.
Coordinator of Handbook Materials

STATE OF IOWA

ERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF INSPECTIONS AND APPEALS
CHARLES H. SWEENEY, DIRECTOR

July 27, 1992

Joyce Brandt, R.N.
Health Education Occupations
University of Iowa
N487 Lindquist
Iowa City, IA 52242

Dear Ms. Brandt:

We have reviewed the University of Iowa competency evaluation program for nurse aides for compliance with the Federal regulations, sections 483.154 (b) (e) and (f).

The competency evaluation program meets the regulations and is approved for use in Iowa.

The testing committee's assistance in revising the test to meet the new regulations is greatly appreciated.

Sincerely,

Pearl Johnson, Bureau Chief
Professional Support Services/Compliance

Karen Mueller

Karen Mueller, R.N. BSN
Health Facilities Training Officer
Professional Support Services/Compliance
Division of Health Facilities
(515) 242-5991

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FAX# 515-242-5022 / TDD# 515-242-6515

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NURSE AIDE COURSE AND COMPETENCY EVALUATION

Overview OBRA (1987) requirements, as outlined by HCFA, require all nurse aides working in nursing facilities to (1) successfully complete an approved course of no less than 75 hours and/or (2) successfully complete a written or oral and skills performance competency test. The course, teachers, and competency tests are approved by the Iowa Department of Inspections and Appeals.

Teacher/Evaluator Approval

Teachers and evaluators for this course must be registered nurses, must have at least two years experience with at least one year being in the provision of long term care and must successfully complete approved teacher training course or document vocational teacher education courses. Community colleges have access to teacher trainer trainers and offer the teacher training program as needed. Upon successful completion of the teacher training an application verifying training and listing work experience is submitted to Program in Health Occupations Education. A certificate verifying successful completion for the teacher preparation will be mailed to participants. The certificate alone does not make a R.N. eligible to teach the course, the R.N, must also comply with the 2 year experience criteria outlined above.

Please see page 5 for process for offering teacher training program.

Course Materials/Written and Skills Competency Tests

The approved 75 hour nurse aide course materials may be purchased from Program in Health Occupations Education, The University of Iowa. The curriculum includes course objectives, outline, skills check list and clinical evaluation. Handout material is also available for an additional copying cost. The address for ordering these materials is:

Program in Health Occupations Education
College of Education
The University of Iowa
N487 Lindquist Center
Iowa City, IA 52242-1529
Phone (319) 335-5316

Community Colleges may obtain written and skills examinations from the Program in Health Occupations Education.

Nurse Aide Programs Offered in High Schools

The approved nurse aide program may be offered in high schools as one of the vocational health occupations components. The criteria for course, program, and teacher approval follows guidelines in this handbook; however, there are additional Department of Education requirements that must be met for Vocational Program approval and to meet the requirements of the vocational standards. If you are planning to offer this on a high school basis and have not done so, please contact the Department of Education, Secondary Health Consultant:

Jane Muhl
Program in Health Occupations Education
The University of Iowa
N471 Lindquist
Iowa City, IA 52242-1529
(319) 335-5319

NURSE AIDE PROGRAM
TEACHER TRAINING

Teacher Requirements for Community Colleges and High Schools

The teacher of the Nurse Aide course must be a Registered Nurse with a minimum of two years experience and one year of that experience must be in long term care. The teacher must also have successfully completed the Teacher Training Program or have validation of Teacher Education Courses and/or Licensure from Board of Educational Examiners. Secondary teachers must be licensed and endorsed to teach secondary nurse aide by the Board of Educational Examiners. For additional information for requirements for licensure contact the Health Consultants at (319)335-5322.

Process for Offering Teacher Training Program for Community College Adult Teachers.

Course is offered by Community Colleges - A list of scheduled courses are available from The Program in Health Occupations Education.

The course must be taught by a qualified teacher trainer (TTT). A list of qualified TTT's on page 6 and 7.

The Teacher Trainer Trainers have copies of the course curriculum, handouts and tapes for evaluation. Copies of these will be available during the training.

Once community colleges have scheduled a teacher training program they should notify Joyce Brandt at Program in Health Occupations Education (PHOE) by completing the application on page 24. PHOE in turn will notify Department of Inspections and Appeals (DI&A) and other interested agencies/persons. In addition, PHOE will mail the community college applications to be completed by the teacher trainee and returned to PHOE. (Use yellow forms on page 25).

Certificates for Successful Completers

The applications returned to PHOE will be used to enter the teacher trainers name on a roster of approved teachers and to complete a certificate verifying successful completion of the teacher training. NO ONE CAN TEACH THE STATE APPROVED COURSE WHO HAS NOT BEEN RECOGNIZED BY PROGRAM IN HEALTH OCCUPATIONS EDUCATION AS A QUALIFIED TEACHER AND HAS ALSO MET THE MINIMUM EXPERIENCE REQUIREMENT OF THE IOWA DEPARTMENT OF INSPECTIONS AND APPEALS.

Certification for Persons with Teacher Training

Persons who are licensed to teach vocational education with appropriate endorsement from the Board of Educational Examiners will be recognized as qualified teachers by completing the application (page 25) and submitting it with a copy of teacher license (certification) to either Jane Muhl or Joyce Brandt at Program in Health Occupations Education. Upon receipt, these teachers will receive certificate that verifies they have met the training requirements. The Department of Inspections and Appeals will review the experience qualifications during the program review.

PROGRAM IN HEALTH OCCUPATIONS EDUCATION
Approved Teacher Trainer Trainers (TTT)

Following is a list of persons certified to teach teacher trainers for the nurse aide course.

Rachel Cacek
Western Iowa Tech. Comm. College
R. R. 1, Box 145
Elk Point, SD 57025
(605) 356-2955

Avis Davis
Program in Health Occupations Ed.
University of Iowa
Iowa City, IA 52242
(319) 322-5322

Joyce Downing
Kirkwood Community College
6301 Kirkwood Blvd. SW
P.O. Box 2068
Cedar Rapids, IA 52406
(319) 398-5626

Sharon Enabuit
North Iowa Area Comm. College
500 College Dr.
Mason City, IA 50401
(515) 756-2465

Glenda Ferguson
Southeastern Community College
Box 52
Niota, IL 62358
(217) 448-8471

Wanda Gaylord
Southeastern Comm. College
1624 Avenue L.
Fort Madison, IA 52627
(319) 372-4442

Belinda Hobson
Western Iowa Tech. Comm. College
4647 Stone Avenue
P.O. Box 265
Sioux City, IA 51102
(712)276-0380

Rosalie Hughes
Northeast Iowa Comm. College
10250 Sundown Road
Peosta, IA 52068
(319) 556-5110

Beverly Luke
Indian Hills Community College
1332 Mowery
Ottumwa, IA 51501
(515) 682-1852

Katy McNally
Des Moines Area Comm. College
2006 Ankeny Blvd.
Ankeny, IA 50021
(515) 964-6353

Connie Messer
Kirkwood Community College
916 Prospect Pl.
Washington, IA 52353
(319) 653-4160

Shirley Meester
Hawkeye Institute of Tech.
R.R. 1
Reinbeck, IA 50669
(319) 989-2095

Margaret Rhoades
Kirkwood Community College
1709 26th St. NW
Cedar Rapids, IA 52405
(319) 396-4433

Dianne E. Schultz
Northeast Iowa Community College
P.O. Box 201
Postville, IA 52162
(319) 864-7838

Rita Takacs
Eastern Iowa Community College
3734 Lorton Avenue
Davenport, IA 52807
(319) 359-9013

Margaret R. Thompson
Iowa Central Community College
R.R. 1, Box 31
Livermore, IA 50558
(515) 332- 2719

Janet Underwood
Indian Hills Community College
Ottumwa Center
525 Grandview
Ottumwa, IA 52501
(515) 683-5179

Rosemarie VanWilligen
Iowa Valley Community College
Route 2, Unit 13, Lot 14
Montezuma, IA 50171
(515) 623- 5182

GENERAL INFORMATION ABOUT TESTING

State Testing Committee

There will be a minimum of 6 active members on the state-wide testing committee. Community College representatives on this committee will have prior experience in test development. A representative from the Department of Inspections and Appeals shall also serve on this committee. Joyce Brandt from the Program in Health Occupations Education shall serve as coordinator/consultant for the testing committee.

The committee shall meet at least once a year to assess/revise/rewrite test items for the written and skill test. If a situation should arise that requires major revision immediately an emergency meeting of the committee will be called.

Variety in Test Forms

There will be several test forms of the written/oral and skills test. This variety in the forms will assure additional test item security. Letters (A - G) will be used to differentiate different forms of the written/oral tests and numbers e.g. Skills Test 1 etc. will be used to designate different forms of the skills tests.

Item Bank

There will be an item bank of a minimum of 400 questions from which to develop the written test forms. There are 27 skills from which to select 4 skills to be included in each skills test (all tests will include communication and handwashing skills tests). Items will be selected randomly and reflect the test plan for the oral/written forms of the test and skills for the skills test will be selected based on scenarios developed which will reflect the skills test plan. (The test plans can be found on pages 10 and 11.)

Quality of Test Items Used

At appropriate intervals item analysis will be done on each test form and results will be used by the testing committee to revise/develop new items. The results of the skills test will be analyzed for revisions of the skills test forms.

Validity - Ability to Measure What Test is Supposed to Measure

Since the curriculum and test plan are designed in accordance with the OBRA requirements for nurse aides, the competency tests measure what is required. The curriculum was developed with the assistance of a state-wide committee and reflects knowledge and skills required to function as a nurse aide in a nursing facility. Validation studies will be ongoing with 1) interpretations from Federal Guidelines, 2) aides who are currently working, 3) employers and 4) changes occurring in the delivery of nursing care in long term care.

Reliability - Consistency of Test to Measure

The Kuder-Richardson formula will be used to determine reliability on each written test form generated. Measures that increase reliability will be used during test development. See previous directions for maintaining a testing environment.

Successful Completion
Individual colleges and facilities will determine the passing score for the course. Candidates must earn 70% or better in both the written and skills competency state examinations to be eligible to continue working as a nurse aide. Each candidate will have three opportunities to successfully complete both written and skills tests.

Administration of Skills and Written Test
The skills, written/oral test may be given in any order or during the same testing period. Tests will be obtained from Program in Health Occupations Education, The University of Iowa. Area colleges that order tests must do so two weeks in advance of the testing date.

Reporting Results
All written and skills scores from the state competency examinations will be mailed to the Department of Inspections and Appeals by Program in Health Occupations Education. The Department will be responsible for obtaining applications for the registry and keeping track of the number of times a candidate has taken competency evaluations. In addition, the Department will maintain a list of all persons registered as nurse aides.

Quarterly Reports
Each testing agency will receive a quarterly report which includes total number of tests administered at the site and state-wide each quarter (college prepared, facility trained, secondary prepared, challenges, no training)--means and pass rate for the state and sites. This report will be prepared by Program in Health Occupations Education and can be used to evaluate course effectiveness etc.

Test Security
The item bank questions and skill tests will be stored on a computer at the Program in Health Occupations (PHOE), The University of Iowa. Copies of various test forms will be kept in a locked file cabinet. Only program staff will have access to the tests. Test that have been completed and returned to PHOE will be shredded using "confidential" shredding services.

Testing Agency
The community colleges will be the only organizations qualified to administer the above described written and skills competency exam. Within each community college there will be a designated Chief Evaluator. The Chief Evaluator will be responsible for ordering exams, maintaining security on the exams, returning exams for scoring, along with skills scores to PHOE. When written/oral scores have been returned to colleges the Chief Evaluator will be responsible for giving scores to candidates as soon as possible.

Costs of the Tests
The Adult and Continuing Education Directors met with the Health Coordinators and set the cost of competency testing as follows:

Written Competency Tests -	$15.00
Skills Competency Tests -	$35.00
TOTAL	$50.00

***If a facility requests the test be offered on site in the facility and the administration incurs additional costs, these costs will be added to testing fee.

NURSE AIDE COURSE
WRITTEN/ORAL TEST PLAN

The written/oral examination will sample critical information from the 75 Hour Course which meets the criteria identified in the Nursing Home Reform Act.

All forms of the test will include 100 test items with 10 items selected from information described in Section I, 20 from information in section II, 20 from Section III, 10 from Section IV, 22 from Section V, and 18 from Section VI.

	Content Area	Percentage of Test Items	Numbers of Items
Section I	Introduction, role of nurse aide, characteristics of residents in facilities, organization of facilities, rules and regulations, legal/ethical considerations, resident rights, resident rights.	10%	10 Questions
Section II	Resident's environment, safety, medical asepsis, CDC, Choking resident, range of motion, bed making, transfer, positioning, ambulation, restraints.	20%	20 Questions
Section III	Assisting the resident with personal hygiene needs--baths, oral hygiene, grooming, shampoo, nail care, elimination and back rubs.	20%	20 Questions
Section IV	Nutritional needs--daily nutritional needs, assisting a resident to eat, preparing a resident for meals and special diets.	10%	10 Questions
Section V	Routine care procedures.--Vital signs, Ht. and Wt., intake and output, collection of urine specimen, and catheter care.	22%	22 Questions
Section VI	Special needs of residents--physical, emotional needs, special procedures for working with residents who have common medical disorders, dementias, mental retardation or mental illness.. Caring for dying resident is also included.	18%	18 Questions
	Total	100%	100 Questions

NURSE AIDE COMPETENCY EXAMINATION

SKILLS TEST PLAN

There will be six skills evaluated in each skill competency examination. Hand washing and communication will always be included in the evaluation and one skill from each of the following levels will be selected for each skill examination.

Level I
Position Urinal
Assisting the Resident with the Bedpan
Make Closed/Open Bed
Perform Back Rub
Prepare Resident for Meal
Measure and Record Oral Temperature with Mercury Thermometer
Provide Oral Hygiene

Level II
Move Resident in Bed or Chair
Position Resident in Bed or Chair
Feed Resident
Measure and Record Pulse and Respiration
Empty Drainage Bag and Record Output
Provide Nail Care
Denture Care

Level III
Apply Restraints
Measures to Assist Conscious Choking Resident
Perform Catheter Care (This will be done on a mannikin)
Obtain Urine Sample
Measure and Record Intake and/or Output
Measure and Record Height and Weight
Dressing/Grooming Resident

Level IV
Make Occupied Bed
Perform Range of Motion
Bed Bath/Partial Bath
Measure and Record Blood Pressure
Transferring Resident from Bed to Chair
Ambulating Resident

TESTING ENVIRONMENT

Testing environment is important to maintain test reliability (consistency). Principles for a good testing environment require the following:

Written Test Environment

Test monitors do not have to have completed the teacher training program, however, monitors must be oriented to process and must use the following directions for administering the written test. Monitors must stay in the test area during the total time candidates are writing the examination.

Classroom area with individual candidate desks or large tables with enough room between candidates to discourage looking on others' answer sheet. The classroom should not be a resident area. Resident areas must be kept for resident use. During testing it should be quiet in the room and there should be no one going in and out of the room. Lighting should be adequate.

Candidates should not talk, make unnecessary noises or chew gum. In general there should be no distractions during the testing period.

Oral Test Environment

Room that is quiet and separate from other student areas. The oral test can be read by a person in special needs area that is does not have a health occupations background (Health personnel may inadvertently give away correct answers when reading the questions) or a tape recording can be used. Each candidate will also be provided with a written test which can be followed as test is read. The candidate may ask for questions to be repeated or may rewind and replay the test items on the tape. The candidate will be responsible for completing the answer sheet.

**Each community college will have three forms of the test on a tape recording that must be kept secure.

Skills Test Environment

The evaluators/testers must have had a minimum of one year experience in caring for elderly/chronically ill and must have completed the teacher training/evaluation program.

Skills testing should be done in a simulated resident area with the appropriate resident unit. The room/area must be separated from other residents/personnel/candidates during testing period. A unit currently occupied by a resident cannot be used for testing. The area should have good lighting, should be quiet and free of distractions or noises. A quiet area separated from testing area should be available for a waiting area for candidates.

Equipment needed to perform the skills test: An unoccupied resident unit should be available. The resident unit should include: bed, overbed stand, bedside stand. Each of the skills test forms identifies the additional equipment that will be needed to complete the skills test. This equipment should be prepared before the test begins.

APPROPRIATE TESTING SITES

Community college classrooms and laboratories that meet the above criteria are excellent testing sites - facilities can be used if they meet the above criteria. Federal Guidelines for administering the competency tests do require the test be given to candidates in the facility if requested. Prior to administering a test in the facility the testing agency needs to evaluate the testing environment to make sure it meets the above criteria. In addition, if the cost of testing is increased because the test is administered in a facility, the additional cost may be added to the testing cost.

PROCESS FOR ORDERING/DISTRIBUTING TESTS

1) Two weeks prior to administration of the exam, the Community College Chief Evaluator will submit a written request for the test to PHOE. The order should include type and number of exams needed for the testing. This should be accompanied by a purchase order for $5.00 per test (written and skills). Some colleges have open P.O. numbers and PHOE charges as tests are used - discuss the options with your director.

2) PHOE staff will fill the order and mail by UPS one week prior to the testing date. The test forms sent to the community colleges will be rotated so different forms can be used for each testing. Written/oral tests will be identified by letters (e.g., Form A) and skills tests will be identified by numbers (e.g., Skills Test 2).

3) Upon receipt of the tests at the community colleges the Chief Evaluator will check/verify test forms, numbers etc. with order invoice. If there is a discrepancy, the Program in Health Occupations will be notified immediately and appropriate corrections will be made. All tests will be secured and keep under lock until the date of administration. The chief evaluator is RESPONSIBLE for test security at the community college. If there is any break in security, the Chief Evaluator must notify Joyce Brandt immediately.

4) Each community college will have three recorded tapes of three different test forms. The Chief Evaluator is also responsible for keeping these tapes secure and rotating the test form for persons who are repeating the test. The written test that corresponds with the tape that will be used must also be ordered from PHOE.

5) On the day the tests are given (written/oral and or skills) the Chief Evaluator will deliver the tests to the evaluators. Tests will be rechecked for correct numbers, forms etc.

6) The test administrator will follow directions for administration of the specific competency examination. Once the test administration is completed the tests will organized by test number, secured by chief evaluator and mailed as soon as possible to PHOE. The only part of the tests that will be retained by community college is the skills summary sheet--identifying score of candidate and verifying that candidate who has failed the skills test has been informed regarding areas of weakness. In addition to returning all test materials, the chief evaluator will also include the candidate names, addresses, classification and scores for all skills test administered. PHOE will mail a copy of these scores to Iowa Department of Inspections and Appeals.

7) Once written/oral score sheets are received, the score sheets will be computer scored. When the scores are received from Testing and Evaluation the scores will be mailed to the colleges administering the test who will be responsible for seeing the candidate gets a copy of the score. Both written and skills scores will be mailed to the registry at the Department of Inspections and Appeals by PHOE. If a candidate failed a written test, a summary sheet (page 22-23) will be mailed to college coordinator who will mail it to candidate with the candidates written/oral score.

NURSE AIDE WRITTEN/ORAL COMPETENCY TEST
CANDIDATE DIRECTIONS

To be read or given to candidates prior to test administration.

FOLLOWING IS PROCESS THAT WILL BE USED FOR WRITTEN ORAL COMPETENCY TESTS. Arrive at the testing site at least 15 minutes before the test is scheduled to begin.

Material to bring with you to the test.

1. Admission slip that is included in this letter.
2. Bring at least 2 number 2 lead pencils with you to the test. You will use the pencils to record your answers.
3. DO NOT bring text books, notebooks or any other materials with you to the test.

Description of the written/oral competency test.

1. The written/oral competency test for nurse aides is a 100 question multiple choice test. There is only one best answer. Please answer all questions since there is no penalty for wrong answers. You will be given two hours to complete the test. The test monitor or reader will inform you of the time remaining for the test by either telling you or writing it on the blackboard.
2. You may not leave the room during the testing period. You are asked not to chew gum or make unnecessary noises that will disturb others taking the test.
3. If taking written test read each question carefully and select the best answer. Record your answers on answer sheet as listed in step 5.
4. If the test is being read or you are using a tape recording of the test listen to each question carefully and select the best answer. You will also be given a written copy of the test if you desire. You may follow along as the test is read. If you are using the tapes you may rewind/replay the tape, if the test is being read you may ask the reader to repeat the question. The reader may not define terms or interpret words on the test. You will record your own answers on the answer sheet as described below.
3. You will be provided an answer sheet to record your answers. In addition, to the answers you will be asked to write your name, social security, test date, test site and a code on the answer sheet. The monitor will give your directions for doing this before the test begins. All answers will be recorded on the answer sheet that will be provided. There is a sample of the answer sheet below, remember answer all questions; however if you skip a question be sure and skip the answer on the answer sheet. Do not write on the test itself.

*If you have other questions you will be able to ask the questions prior to testing.

Test Results

You will receive the test results in 2 - 3 weeks from the community college where you took the test. The results will be sent to the Nurse Aide Registry at the same time they are sent to the community college. The results will not be shared with anyone but the registry and community college. If you want your employer to receive a copy you must sign a release form. You are required to achieve a 70% or better on the written test. If you do not receive this minimum score you will also receive an analysis of how you did with the test results. Use this analysis to prepare for retesting. You may take the written test three (3) times to achieve the minimum pass score. If you do not receive a pass score by the third test you must retake the course.

NURSE AIDE COMPETENCY SKILLS TEST
CANDIDATE DIRECTIONS

This information is to be given to candidates either verbally or in writing prior to the test.

To: All persons taking the skills competency test for nurse aide
PLEASE READ THE FOLLOWING DIRECTIONS CAREFULLY BEFORE COMING TO THE TESTING SITE.

1. You must bring your admission card with you to the testing site or you will not be permitted to take the examination.
2. The admission card has the place and the time you will be taking the skills test, please report to the site 15 minutes early. When you arrive check in with test administrators.
3. It is recommended you dress neatly and clean. You may wear your uniform. BE SURE AND WEAR A WATCH WITH A SECOND HAND.
4. The skill test will be designed as a realistic nurse aide assignment. It will consist of 4 skills taken from the OPRA list of skills for testing with handwashing and communication/resident rights included in every skills test. Prior to beginning the skills test you will be given a test situation and oriented to the testing site.

   Following is a SAMPLE of a skilled test situation:
   You have been assigned to provide care for Mr. Jones today. After checking with the nursing supervisor you learn you must give him a bed bath, assist with oral hygiene, transfer him to a wheel chair, take his TPR and record them.
   During this skills test you will be evaluated on
   1. Handwashing
   2. Giving a bedbath - Level IV
   3. Giving oral hygiene - Level I
   4. Communication skills with Mr. Jones
   5. Transferring to a wheel chair - Level III
   6. Taking and recording TPR - Level II

   **One skill has been taken from each category.

   IF YOU HAVE ANY QUESTIONS ASK THEM AT THIS TIME BEFORE THE TESTING BEGINS.

5. The test will be given in a nursing laboratory and there will be a resident unit set up. All equipment needed for the skills test will be available at the testing site. There will be a person acting as a resident and one person who is doing the skill evaluation. You should talk with the resident but you may not ask questions about the skills test. The skills test evaluation will be similar to the skills checklist required in the revised 75 hour Nurse Aide Course.
6. You must receive 70% on the skills checklist to successfully complete the test. Once you have finished the skills test return to the waiting room and as soon as the evaluator has finished scoring the test they will notify you how you have done on the test. If you have not achieved a 70% or better the evaluator will explain the areas for improvement and ask you to sign verifying they have reviewed this with you. The test score will be sent to the registry department in the Department of Inspections and Appeals. You will have three opportunities to pass the skills test.
7. If you have questions about this prior to coming to the testing, please contact the health coordinator at the community college where you are taking the test.

MONITOR'S DIRECTIONS FOR ADMINISTERING WRITTEN NURSE AIDE EXAMINATION

Please read carefully and follow these guidelines when administering the Written Nurse Aide Competency Examination.

1. Prior to the test obtain the correct number of written examinations, score sheets, list of persons taking the test, and number 2 lead pencils from the chief evaluator responsible for test security.

2. Be sure and check numbers, test forms with the coordinator prior to going to administration site. Return tests to chief evaluator immediately following completion.

3. Be at the administration site at least 15 minutes prior to testing time. Once you arrive on site check the room set-up and be sure there is adequate seating, good lighting and freedom from noise and disturbance.

4. Check in each candidate who should have an admission slip to be allowed to take the examination. If candidate brings notebooks, papers, texts with them have them leave at central location at front of room, where they may pick them up when test is finished.

5. Start the test on time....DO NOT ADMIT ANYONE AFTER THE OFFICIAL STARTING TIME. NO ONE SHOULD BE ADMITTED AFTER YOU HAVE DISTRIBUTED TESTS.

6. Once all of the test takers have been seated, distribute a test booklet and score sheet to each test taker. Direct the test taker NOT to open booklet until you have finished with the following directions.

7. THE FOLLOWING DIRECTIONS SHOULD BE READ AND EXPLAINED TO ALL TEST TAKERS PRIOR TO BEGINNING THE TEST.

   a. I will now give you directions for taking this examination. I will not be able to answer any questions after you start taking the test so please ask any questions you have now.
   b. This written competency test consists of 100 questions related to the work of a nurse aide. You will be given two hours to finish the test. I will write the time remaining on the blackboard at 1 hour, 1/2 hour and 15 minutes.
   c. You may not leave the room during testing and we ask that you do not chew gum or make other unnecessary noise which will disturb fellow test takers.
   d. The test is a 100 questions multiple choice test. There is only one best answer. Please answer all questions - there is no penalty for answering questions incorrectly. Remember however, if you do not answer a question to be sure and skip the corresponding answer on the answer sheet. Note: Question numbering on answer sheet. Tell them NOT TO WRITE ON THE TEST BOOKLET ITSELF.
   e. Read each question carefully. Select the <u>best</u> answer and using the number 2 pencil provided fill in the circle completely that corresponds with the letter in front of the answer you have chosen - these directions are in writing at the front of the written test you have been given and you may refer to them. (Answer any questions pertaining to this.)

(CONTINUED ON NEXT PAGE)

f. Now have test takers take out answer sheet and fill in name, identification number (which is social security number), test date, and use optional code (see page 18).
Once testers have completed information (name, date etc.) have them blacken the corresponding circles below. On Blanks at top have them fill in following - Instructor = Brandt, Dept. = Form (appropriate for form of test taking), Course = Nurse Aide.

g. Tell test takers once they have finished the test to bring the test booklet and answer sheet to you. They should receive results in about 2-3 weeks in mail form the community college administering the test.

h. Now have the testers begin the test...begin timing.

DIRECTIONS FOR COMPLETION OF THE ANSWER SHEET

Have candidates complete this part. It is up to test administrator to make sure all areas have been completely finished.

1. Last name first - space between last and first name.
2. Blacken (all) corresponding letters.
3. Identification number: ALL 9 numbers of social security number. Write in space -blacken circle.
4. Test Date: Month Blackened. Date in year in space and blackened.
5. Optional Code: MUST BE COMPLETED!!! Designates testing site and candidate classification.
   Testing site is a two digit number designating Community College where test given. e.g. 01-16
   For Community Colleges from 1-9, please use a 0 before college to hold computer place.
   Last two numbers designate classification as follow:
   - 01 - Completed 75 Hr. approved course at college
   - 02 - Completed 75 Hr. approved course at facility
   - 03 - Completed 75+ Hr. approved course at high school
   - 04 - Job Corp Trained
   - 05 - Oral Examination (read or tape)
   - 06 - Health Occupations Related (nursing, EMT-A, etc.)
   - 07 - Part of 75 Hr. Course - dropped before completed.
   - 08 - No formal training
   - 09 - Challenge e.g. 60 Hr. course/2Yrs. not working/ transfer another state
   - 10 - Other - doesn't fit any category above
6. Fill in circle that corresponds with test form. If Form is above D-simply write it in under D.

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BEST COPY AVAILABLE

SIDE 1

PRINT YOUR LAST NAME, SKIP A BOX, PRINT YOUR FIRST NAME AND MIDDLE INITIAL.
BLACKEN THE CORRESPONDING LETTER IN EACH GRID

(1) LAST NAME, THEN FIRST NAME AND MIDDLE INITIAL

BRANDT JOYCE

(2)

TEST FORM (A) (B) (C) (D) (6)

(3) IDENTIFICATION NUMBER

4 2 1 1 2 3 4 5 6

(4) TEST DATE

MO: JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

DAY: 2 0

YR: 4 2

(5) OPTIONAL CODES

A B C D E F

0 3 C 1

DO NOT USE

18

DIRECTIONS FOR ADMINISTERING ORAL TEST

The oral test can be administered with a reader or by having the candidate use one of the tape recorded tests. A room that is quiet and secluded should be used. Candidates should not have access to course materials during testing.

Readers: Test readers should not be health professionals. There is too much of a chance for health professionals to inadvertently identify the answer.

Tape Monitors: If the candidate uses a recorded test (tape), the monitor should assist the candidate with completing general information on the answer sheet. The general directions about not leaving testing area, how to record answers etc. etc. as found on written instructions should be explained. In addition, the monitor should show the candidate how to use the tape player. The candidate should be observed during the total testing period.

Materials: All candidates should have a written copy of the test, the answer sheet, and a number 2 lead pencil. The test monitor should assist the candidate to complete data on the answer sheet - name, social security number, date, code (see page 18 - not the code for having test read is 05.

DIRECTIONS FOR ADMINISTERING THE SKILLS TEST

Please read carefully and follow these guidelines when administering the Nurse Aide Skills Competency Test.

1. Prior to the test, the chief evaluator will have obtained the correct number of tests from the testing agency. There will be one form skills test for each ten candidates taking the test. (Unless chief coordinator ordered test forms based on different number of candidates.)
2. Be sure you check the test numbers with chief examiner before testing begins.
3. Chief evaluator will have obtained the equipment needed for each testing station prior to the testing (there will be a testing station set up for each different test form used during testing period - no more than 10 candidates will be tested at each station.)
4. Be at the administration site at least 15 minutes prior to testing. Review the scenario and evaluation sheets for the testing station assigned. Discuss the situation with person assisting you at the station (preferably this person will be another qualified evaluator). Be sure you both agree on how the evaluation will be conducted. Check to make sure you have all the equipment you need.
5. Orient the candidate to the resident care unit prior to the testing situation. Be sure candidate knows where all equipment is kept, how to work the equipment e.g. raise/lower bed etc.
6. A copy of the scenario for the skill test will be given to the candidate prior to being brought to the test station. The candidate should be oriented to the nursing set up. This is the only time the candidate may ask questions regarding scenario. Once the candidate is brought to the station the candidate must complete the skills listed on the test.
7. Each candidate will be judged on 6 skills. Two (the communication and handwashing) are included in each test; the other four come from the test plan provided previously in this Handbook.
8. The evaluator observing the nurse aide performance will complete each skill evaluation form as they observe the candidate. Mark only if the candidate accurately completed the performance listed on evaluation sheet. Assign the listed number of points prescribed if candidate successfully completes step. NO PARTIAL POINTS ARE TO BE GIVEN: CANDIDATE GETS ALL OR NONE.
9. There are some critical incidents identified on the checklist that must be correctly completed by candidate or the candidate will receive 0 points for that skill. This does not necessary mean the candidate fails the skills test.
10. When candidate has completed test have them return their copy of the scenario - return with the rest of the test to the chief evaluator - who will return to testing agency.
11. Remove the back sheet of the competency test - fill in the scores the candidate has earned and calculate total score. Determine if the candidate received enough points to successfully complete test - 70% or better. The back sheet becomes a part of candidate record at the college.
12. If the candidate failed the test (less than 70%) go over what the candidate missed with candidate and have them sign that you have discussed what they missed with them.
13. Inventory all of the tests you have received. Put the tests in numerical order and return to chief evaluator who will return to testing agency.

NURSE AIDE CODING SYSTEM

The candidates taking the nurse aide competency written and skills test have been prepared for the nurse aide role in a variety of ways. To determine the effectiveness of the competency written and skills test and the candidates preparation for the test it is necessary for the administrators to have data to compare results on the test. In order to achieve this end we need to differentiate between candidates preparation - therefore we will use codes to designate the preparation. The codes will be recorded on written test in the optional codes area and in an appropriate place on the skills test. The code will consist of four numbers, the first two numbers will designate the community college number designating test site (01 - 17 with the Peosta attendance center in area I being 17) and the last two numbers will designate candidate preparation. You all should know your area college number and following are the numbers to designate preparation:

01 - 75 Hr. Course from a Community College
02 - 75 Hr. Course from Facility based program
03 - 75 Hr. Course from Secondary Programs
04 - Job Corp Trained
05 - Oral Examination
06 - Health Occupations/related e.g. PN, EMT-A, etc.
07 - Part of 75 Hr. course the dropped - (16 Hr. Video)
08 - No Formal Training
09 - Challenge (60 Hr. course - 2 Yrs. not working - Program in other state)
10 - Other

***Please start using this code July 1, 1993.

APPLICATION FOR NURSE AIDE COMPETENCY TEST

Directions: This must be completed and returned with a copy of nurse aide certificate to _____, three weeks prior to testing date. Use a black pen to complete all items. If you have questions please contact

Name _____
Last First Initial

Address _____
Street

_____
City State Zip

Phone (home) _____ Work _____

Social Security Number _____

I am applying for (Please put an X all spaces that are applicable.)

_____ Skills Competency Examination
_____ Written Competency Examination
_____ Written Competency Examination (Read to me)

Date of Testing Requested_____

Testing History

I have (Please put an X in the correct space.)

_____ Never taken either test before.
_____ Taken the written test before. (_____times)
_____ Had the oral test read to me before. (____ times)
_____ Taken skills test before. (_____ times)

The admission slip below will be completed by community college and returned to you prior to testing date. Please be sure you bring it with you.

COMPETENCY TEST ADMISSION SLIP

This is your admission to the testing and MUSI be brought with you to be allowed to take the test.

_____ is to be admitted

to Nurse Aide Competency test at _____ on

_____. Written/oral test will be given at

_____ o'clock and you are scheduled for Skills test at _____ o'clock.

Completed Approved Course at_____

The University of Iowa
Iowa City, Iowa 52242

College of Education
Program in Health Occupations Education
N487 Lindquist Center

319/335-5316

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To: Persons who have failed written nurse aide competency test

From: Program in Health Occupations Education
University of Iowa

RE: Your results on written competency test

The OBRA regulations and state rules require the nurse aide written competency test agency to provide all persons who take and fail the written examination with a summary of their result.

Attached you will find such a summary sheet. 70% is the required passing score on the written examination. Your score was which is not passing. The rules state you may retake the written test 3 times to achieve the 70% or better. The rules also allow you to have the test read to you if you feel your reading comprehension is the problem. If you want the test read to you, please contact the Health Occupations Coordinator at the area college where you want to take the test. As you review the attached summary sheet prior to retesting, note those areas where you missed the most questions on the written test. These are the areas you should study before retesting.

If you have any questions or concerns, please call Joyce Brandt at (319) 335-5322.

PROGRAM IN HEALTH OCCUPATIONS EDUCATION
University of Iowa

SUMMARY OF PERFORMANCE OF WRITTEN NURSE AIDE COMPETENCY EXAMINATION

Name_____ S.S._____

Examination Site_____ Date_____
(Community College)

Test Form_____

	TEST DESCRIPTION		TESTER RESULTS	
Description of Content	Possible Points	Percent of Test Grade	Score Earned	Percent of Final G
Introduction to role of Nurse Aide, Overview of Nursing Facilities, Rules and Regulations, Resident Rights, Communication, Legal and Ethical Nurse Aide Responsibilities	10	10%		
Residents environment - safety-CDC Precautions-handwashing, bedmaking, range of motion, restraints	20	20%		
Assisting the resident with personal care and hygiene (Baths, showers, nail care, grooming, positioning, ambulation, transferring.	20	20%		
Nutritional needs, preparing resident for meals, diets, emergency care for choking resident	10	10%		
Routine care procedures. TPR, B.P., Ht., Wt., I&O, Collection of Specimen, catheter care, osotmy care.	22	22%		
Special needs or residents, emotional, cognitive disorders, common medical disorders, death and dying	18	18%		
TOTALS	100	100%		

PROGRAM IN HEALTH OCCUPATIONS EDUCATION

NOTIFICATION OF SCHEDULED TEACHER TRAINING PROGRAM FOR
REVISED 75 HOUR NURSE AIDE COURSE

Instructor's Name _____

Address _____

_____

Agency Offering Course _____

Site Where Course is Being Offered _____

Address _____

_____

Dates and Times Program is Being Offered _____

_____

Include 4 brochures developed for this program.

Mail at lest two weeks in advance to:

Joyce Brandt
Program in Health Occupations Education
The University of Iowa
N479 Lindquist Center
Iowa City, IA 52242-1529

If you have questions, please call Joyce Brandt at (319) 335-5322.

Send a list of successful completers and their addresses to Joyce Brandt (at address listed above). They will receive certificates by return mail.

PROGRAM IN HEALTH OCCUPATIONS EDUCATION
TRAIN-THE-TRAINER APPLICATION

Name: _____

Address: _____

_____

Telephone Number: _____ Social Security Number: _____

RN Iowa Licensed Number: _____

Work Experience - The OPRA regulations require the teacher to have at least two years experience with a minimum of one year being in long term care.

_____

_____

_____

_____

List any teaching experience you have had (not required):

_____

_____

THE ABOVE ANSWERS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND ALL STATEMENTS CONTAINED IN THIS APPLICATION MAY BE INVESTIGATED.

_____ _____
Signature Date

- -

_____ has successfully completed the
(applicant's name)
Train-The-Trainer Program to teach the 75 hours nurse aide program on

_____ at _____ and I recommend he/she
(date) (location)
receive a certificate.

_____
(Train-The-Trainer-Trainer - TTT Signature)

Return to Program in Health Occupations Education, The University of Iowa, N479 Lindquist Center, Iowa City, IA 52242-1529. Upon receipt, the train-the-trainer's name will be submitted to Iowa Department of Inspections and Appeals and a certificate will be mailed to the train the trainer.

apply for onsite proficiency testing of a hospital laboratory. Thus, Medicare reimburses State agencies for onsite proficiency testing activity in independent and hospital laboratories subject to the following stipulations:

o If onsite proficiency testing also benefits your licensure program, you must pay your fair share of the cost of such testing.

o Maintain a record of funds expended for onsite proficiency testing and attach a statement to your quarterly expenditure report showing expenditures for:

- Person-years as computed per instructions in §4760;
- Salaries;
- Percent of salaries charged as retirement and fringe benefits;
- Indirect cost rate and base (i.e., salaries and wages or total direct cost); and
- Cost of materials used in testing.

The statement also shows the respective shares of the total costs attributed to the Medicare and State licensure programs. Include onsite proficiency testing cost projections in the FY budget requests. If there is any question concerning whether a particular onsite proficiency testing expenditure is reimbursable, contact the RO for resolution.

4131. DEEMING AND WAIVER OF NURSE AIDE TRAINING AND COMPETENCY EVALUATION REQUIREMENTS

The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) included provisions prohibiting facilities from using as nurse aides any individuals who have not successfully completed a nurse aide training and competency evaluation program or competency evaluation program approved by the State. OBRA 1987 and OBRA 1989 deemed some individuals to meet this requirement and permitted States to waive this requirement for others. All individuals who are deemed to have met the nurse aide training and competency evaluation requirements or for whom you have waived the requirement to complete a competency evaluation program must be included in the nurse aide registry described in §4141.

A nurse aide is deemed to satisfy the requirement of completing a nurse aide training and competency evaluation program if, before July 1, 1989, he or she had completed a nurse aide training and competency evaluation program of at least 60 hours and had made up at least the difference between the number of hours in the program he or she completed and 75 hours in supervised practical nurse aide training or in regular in-service nurse aide education.

A nurse aide is deemed to satisfy the requirement of completing a nurse aide training and competency evaluation program if, before July 1, 1989, the individual was found competent (whether or not by the State) after the completion of nurse aide training of at least 100 hours duration.

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A nurse aide is deemed to satisfy the requirement of completing a nurse aide training and competency evaluation program if, before July 1, 1989, the individual was found competent (whether or not by the State) after the completion of nurse aide training of at least 100 hours duration.

You may deem an individual to have completed a nurse aide training and competency evaluation program if the individual completed, before July 1, 1989, a nurse aide training and competency evaluation program that you determine would have met the requirements for approval at the time it was offered.

You may waive the requirement for an individual to complete a nurse aide competency evaluation program for any individual who can demonstrate to your satisfaction that he or she has served as a nurse aide at one or more facilities of the same employer in the State for at least 24 consecutive months before December 19, 1989.

Any individual described above may be used as a nurse aide by a SNF if that individual is also competent to perform nursing or nursing-related services.

4132. NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND COMPETENCY EVALUATION PROGRAMS

OBRA 1987 requires States to specify those nurse aide training and competency evaluation programs and those competency evaluation programs they approve. Follow the requirements detailed in §§4132.1 through 4132.3 when reviewing and approving programs and when withdrawing approval from programs. You may choose to offer your own training and competency evaluation programs and/or competency evaluation programs as long as they meet these requirements.

4132.1 Approval of Programs.--If you do not choose to offer a nurse aide training and competency evaluation program or competency evaluation program, you must review and approve or disapprove all nurse aide training and competency evaluation programs and competency evaluation programs upon request. You may approve nurse aide training and competency evaluation programs and competency evaluation programs offered by any entity as long as the requirements for approval are met.

A. Requirements for Approval of Programs.--Before approving a nurse aide training and competency evaluation program or competency evaluation program:

- o For nurse aide training and competency evaluation programs, determine whether the requirements of §4132.2 are met;
- o For nurse aide competency evaluation programs, determine whether the requirements of §4132.3 are met; and
- o In all reviews other than the initial review, visit the entity providing the program.

B. Time Frames for Review.--Within 90 days of a request to review a program or receipt of additional information from a requester, you must:

- o Advise the requestor whether or not the program has been approved; or
- o Request additional information.

You may not grant approval of a program for more than 2 years. You must require programs to notify you when there are substantive changes to the program within the 2-year period and review programs to which substantive changes are made.

C. Prohibition of Program Approval.--Do not approve nurse aide training and competency evaluation programs or competency evaluation programs offered by or in a SNF if, in the 2 years prior to your review, that SNF:

- Has operated under a waiver under §1819(b)(4)(C)(ii)(II) of the Act;
- Has been subject to an extended (or partial extended) survey under §1819(g)(2)(B)(i) of the Act;
- Has been assessed a civil money penalty described in §1819(h)(2)(B)(ii) of the Act of not less than $5,000; or
- Has been subject to a remedy described in §§1819(h)(2)(B)(i) or (iii) or 1819(h)(4) of the Act.

Do not (until 2 years since the penalty was assessed has elapsed) approve nurse aide training and competency evaluation programs or competency evaluation programs offered by or in a SNF, that, within the 2-year period beginning on October 1, 1988:

- Had its participation terminated under the State plan under title XVIII of the Act;
- Was subject to a denial of payment under title XVIII of the Act;
- Was assessed a civil money penalty of not less than $5,000 for deficiencies in nursing facility standards;
- Operated under temporary management appointed to oversee the operation of the facility and to ensure the health and safety of its residents; or
- Pursuant to State action, was closed or had its residents transferred.

D. Withdrawal of Approval.--You must withdraw approval from:

- Any nurse aide training and competency evaluation program or competency evaluation program described in subsection C, and
- Any nurse aide training and competency evaluation program or competency evaluation program if the entity offering the program refuses to permit unannounced State visits. (Also, any facility that refuses to permit unannounced State visits is subject to having its provider agreement terminated.)

You may withdraw approval of a nurse aide training and competency evaluation program or competency evaluation program if you determine that a[illegible] of the requirements described in §§4132.2 and 4132.3 are not met by the program. You may also withdraw approval from any program which does not meet any requirements you have in excess of the minimum Federal requirements or which otherwise fails to meet your standards.

When withdrawing approval from a nurse aide training and competency evaluation program or a competency evaluation program--

- Notify the program in writing, indicating the reason or reasons for withdrawal of approval; and

o In the case of a training and competency evaluation program, permit students who have already started the program to finish it.

4132.2 Requirements for Nurse Aide Training and Competency Evaluation Programs.--

A. Hours of Training.--A nurse aide training and competency evaluation program must consist of a minimum of 75 clock hours of training for you to approve it. You may require addition hours of training if you wish.

B. Restrictions on Activities of Students in a Nurse Aide Training and Competency Evaluation Program.--Do not approve a program unless it ensures that:

o Students do not perform any services for which they have not trained and been found proficient by the instructor; and

o Students providing services to residents are under the general supervision of a licensed nurse or a registered nurse.

C. Instructor Qualifications.--The training of nurse aides must be performed by or under the general supervision of a registered professional nurse who possesses a minimum of 2 years of nursing experience, at least 1 year of which must be in the provision of long-term care facility services. Instructors of nurse aides must have completed a course in teaching adults or have experience in teaching adults or supervising nurse aides. In a facility-based program, the training of nurse aides may be performed under the general supervision of the director of nursing, who is prohibited from performing the actual training.

Other individuals may supplement the instructor. The following list contains suggestions of those who might be useful in a nurse aide training and competency evaluation program:

o Registered nurses;

o Licensed practical/vocational nurses;

o Pharmacists;

o Dietitians;

o Social workers;

o Sanitarians;

o Fire safety experts;

o Nursing home administrators;

o Gerontologists;

o Psychologists;

o Physical and occupational therapists;

o Activities specialists;

o Speech/language/hearing therapists; and

- Resident rights experts.

The program may utilize individuals from fields other than those listed as examples if needed to meet the planned program objectives for a specific unit. Supplemental personnel must have a minimum of 1-year of experience in their fields. You may wish to require that these individuals be, where applicable, licensed, registered, and/or certified in their field.

D. Minimum Curriculum Requirements.--The objective of nurse aide training and competency evaluation programs is to enable nurse aides to provide quality services to residents. Therefore, a nurse aide training and competency evaluation program must contain at least these minimum curriculum requirements for you to approve it. You may also specify additional areas to be included if you wish.

Within the minimum 75 hours of training, at least 16 hours must be devoted to supervised practical training. Supervised practical training is defined as training in a laboratory or other setting in which the student demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or a licensed practical nurse. A program must also include at least 16 hours of classroom instruction prior to a trainee's direct involvement with a resident. This instruction must include the following:

- Communication and interpersonal skills;
- Infection control;
- Safety/emergency procedures, including the Heimlich maneuver;
- Promoting residents' independence; and
- Respecting residents' rights.

The curriculum must also include training in the following areas:

- Basic Nursing Skills--
  - Taking and recording vital signs;
  - Measuring and recording height and weight;
  - Caring for the residents' environment;
  - Recognizing abnormal changes in body functioning and the importance of reporting such changes to a supervisor. Some examples of abnormal changes are:
    - + Shortness of breath;
    - + Rapid respiration;
    - + Fever;
    - + Coughs;
    - + Chills;
    - + Pains in chest;

+ Blue color to lips;
+ Pain in abdomen;
+ Nausea;
+ Vomiting;
+ Drowsiness;
+ Excessive thirst;
+ Sweating;
+ Pus;
+ Blood or sediment in urine;
+ Difficulty urinating;
+ Frequent urination in small amounts;
+ Pain or burning on urination; and
+ Urine has dark color or strong odor; and

- Caring for residents when death is imminent.

o Personal Care Skills--

- Bathing;
- Grooming, including mouth care;
- Dressing;
- Toileting;
- Assisting with eating and hydration;
- Proper feeding techniques;
- Skin-care; and
- Transfers, positioning, and turning.

o Mental Health and Social Service Needs--

- Modifying aide's behavior in response to resident's behavior;
- Awareness of developmental tasks associated with the aging process;
- How to respond to resident behavior;
- Allowing residents to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity; and
- Utilizing resident's family as a source of emotional support.

o Care of cognitively impaired residents:

- Techniques for addressing the unique needs and behaviors of individuals with dementia (Alzheimer's and others);

- Communicating with cognitively impaired residents;

- Understanding the behavior of cognitively impaired residents;

- Appropriate responses to the behavior of cognitively impaired residents; and

- Methods of reducing the effects of cognitive impairments.

o Basic Restorative Services.--The nurse aide should be able to demonstrate skills which incorporate principles of restorative nursing, including:

- Training the resident in self-care according to the resident's abilities;

- The use of assistive devices in transferring, ambulation, eating, and dressing;

- Maintenance of range of motion;

- Proper turning and positioning both in bed and chair;

- Bowel and bladder training; and

- Care and use of prosthetic and orthotic devices.

o Residents' Rights.--The nurse aide should be able to demonstrate behavior which maintains residents' rights, including but not limited to:

- Providing privacy and maintenance of confidentiality;

- Promoting the resident's right to make personal choices to accommodate their needs;

- Giving assistance in resolving grievances and disputes;

- Providing needed assistance in getting to and participating in resident and family groups and other activities;

- Maintaining care and security of resident's personal possessions;

- Providing care which maintains the resident free from abuse, mistreatment, and neglect; and reporting any instances of such treatment to appropriate facility staff; and

- Avoiding the need for restraints in accordance with current professional standards.

E. Competency Evaluation Component.--All nurse aide training and competency evaluation programs must contain competency evaluation procedures that meet the requirments specified in §4132.3.

F. Prohibition of Charges.--No nurse aide who is employed by, or who has an offer of employment from, a facility in the date on which the aide begins a nurse aide training and competency evaluation program may be charged for any portion of the program (including any fees for textbooks or other required course materials). If an individual who is not employed, or does not have an offer to be employed as a nurse aide, becomes employed by, or receives an offer of employment from, a facility not later than 12 months after completing a nurse aide training and competency evaluation program, the State must provide for the reimbursement for costs incurred in completing the program on a pro rata basis during the period in which the individual is employed as a nurse aide.

4132.3 Requirements for Nurse Aide Competency Evaluation Programs.--

A. Notification to Individual.--You must provide advance notice to any individual who takes the competency evaluation that a record of the successful completion of the evaluation will be included in the nurse aide registry.

B. Content of the Competency Evaluation Program.--Competency evaluations must consist of two components: a written or oral examination and a skills demonstration program. The written or oral examination must:

- o Allow aides to choose between a written and an oral examination;
- o Address each item specified in paragraph D of §4132.2.D;
- o Be developed from a pool of test questions, only a portion of which is used in any one examination;
- o Use a system that prevents disclosure of both the test questions and the individual competency evaluations; and
- o If oral, must be read from a prepared text in a neutral manner.

The skills demonstration must consist of a demonstration of randomly selected items drawn from a pool consisting of the tasks generally performed by nurse aides. This pool of skills must include all of the personal care skills listed in paragraph D of §4132.2.

C. Administration of the Competency Evaluation Program.--The competency evaluation may be administered and evaluated only by--

- o The State directly; or
- o A State approved entity which is not the SNF which provided the training.

No nurse aide who is employed by, or who has an offer of employment from, a facility on the date on which the aide begins a nurse aide competency evaluation program may be charged for any portion of the program. If an individual who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility not later than 12 months after completing a nurse aide competency evaluation program, the State must provide for the reimbursement of costs incurred in completing the program on a pro rata basis during the period in which the individual is employed as a nurse aide.

The skills demonstration component of the evaluation must be--

- o Performed in a facility or laboratory setting similar to the setting in which the individual will function as a nurse aide; and
- o Administered and evaluated by a registered nurse with at least 1 year's experience in providing care for the elderly or the chronically ill of any age.

D. Proctoring.--The competency evaluation may, at the nurse aide's option, be conducted at the facility in which the nurse aide is or will be employed unless the facility is described in paragraph C of §4132.1.C.

You may permit the competency evaluation to be proctored by facility personnel if you find that the procedure adopted by the facility assures that the competency evaluation program:

- o Is secure from tampering;
- o Is standardized and scored by a testing, educational, or other organization approved by the State; and
- o Requires no scoring by facility personnel.

You must retract the right to proctor nurse aide competency evaluations from facilities in which you find any evidence of impropriety, including evidence of tampering by facility staff.

E. Successful Completion of the Competency Evaluation Program.--You must establish a standard for successful completion of the competency evaluation. To complete the competency evaluation successfully, an individual must pass both the written or oral examination and the skills demonstration. A record of successful completion of the competency evaluation must be included in the nurse aide registry described in §4141 within 30 days of the date the individual is found to be competent.

F. Unsuccessful Completion of the Competency Evaluation.--If an individual does not complete the evaluation satisfactorily, the individual must be advised--

- o Of the areas which he or she did not pass; and
- o That he or she has at least three opportunities to take the evaluation.

You may impose a maximum on the number of times an individual may attempt to complete the competency evaluation successfully, but the maximum may be no less than three.

IA93CD01

75 HOUR NURSE AIDE COURSE

Developed By:

Program in Health Occupations Education
College of Education
The University of Iowa
N487 Lindquist Center
Iowa City, IA 52242-152[illegible]

In Cooperation With:

Bureau of Technical and Vocational Education
Department of Education

Revised
July 1993

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ACKNOWLEDGMENTS

This Nurse Aide course has evolved from the efforts of many institutions and individuals in behalf of their commitment to help provide an educational program for the long term care facilities' nurse aides. These materials are for the use of educational institutions and the long term care facilities in their efforts to provide individuals with a course that meets the requirements of Nursing Home Standards in the 1988 Budget Reconciliation Bill.

Appreciation is expressed to the following who assisted with this revision of the course:

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Jerri Dean, Southeastern Community College
Joyce Downing, Kirkwood Community College
Carol Hartwig, Secondary Health Occupations
Belinda Hobson, Western Iowa Tech Community College
Rosalie Hughes, Northeast Iowa Community College
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To the extent that this course is relevant and useful, the credit must be attributed to previous curriculum committees and those named above. It is hoped that this course will fulfill the expectation of providing excellent preparatory programs which will be tailored to the educational needs of the nurse aide.

Joyce Brandt, Ph.D.
Project Coordinator

July 1993

STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF INSPECTIONS AND APPEALS
CHARLES H. SWEENEY, DIRECTOR

July 24, 1992

Joyce Brandt, R.N
Health Occupations
University of Iowa
N471 Lindquist
Iowa City, IA 52242

Dear Ms. Brandt:

Our Department has reviewed the July 1992 University of Iowa 75 hour nurse aide curriculum to assure it meets the requirements for course content as specified in Section 483.152(b) of the Federal Register.

The July 1992 University of Iowa nurse aide course meets those requirements and is approved for use in approved nurse aide training programs.

Since the nurse aide course has been significantly revised, the July 1989 University of Iowa 75 hour nurse aide course will no longer be approved for use in nurse aide training programs.

Your continued dedication to provide quality education for nurse aides in Iowa is greatly appreciated. Please extend our thanks to the committee members who so graciously gave of their time in the revision of the nurse aide course.

Sincerely,

Pearl Johnson, Bureau Chief
Professional Support Services/Compliance

Karen Mueller RN

Karen Mueller, R.N. BSN
Health Facilities Training Officer
Professional Support Services/Compliance
Division of Health Facilities
(515) 242-5991

HEALTH FACILITIES DIVISION / LUCAS STATE OFFICE BUILDING / DES MOINES, IOWA 50319-0083 / 515-281-4115
FAX# 515-242-5022 / TDD# 515-242-6515

NURSE AIDE COURSE

Course Description - This 75 hour nurse aide course has been revised to better meet the training requirements of The Omnibus Budget Reconciliation Act of 1987 (OBRA) for aides working in nursing facilities (NF) and skilled nursing facilities (SNF). Emphasis in the course is on students achieving a basic level of knowledge and demonstrating skills to provide safe, effective resident care. The course has been developed in six units of study. These units include:

Unit I - Introduction to the course, characteristics and functions of effective nurse aides, overview of nursing facilities and skilled nursing facilities, methods to properly communicate, legal/ethical requirements, individuality, rights and needs of residents in nursing facilities.

Unit II - Residents' environment, aide's responsibility in maintaining a safe environment. Skills include medical asepsis, handwashing, Universal precautions, fire and disaster plans, bed making, transferring residents, range of motion and safe use of restraints.

Unit III - The aide's role in assisting the resident to achieve their personal hygiene needs is stressed. Skills taught include oral hygiene care, baths, showers, whirlpool, nail care, grooming needs, shampooing, shaving and assisting with elimination needs.

Unit IV - Nutritional needs of people are discussed. Methods of assisting the resident to meet these needs including preparing the resident for a meal and feeding a resident.

Unit V - Routine care procedures that an aide is expected to perform. The skills include vitals, obtaining resident height and weight, intake and output, obtaining a specimen (urine mid-stream), and urinary care.

Unit VI - Emphasizes needs of residents with special conditions, observations that should be made and reported by the aide, ways the aide can modify their behavior in response to resident's behavior, caring for the dying resident.

**A list of the competencies (knowledges and skills) taught in the course can be found on following pages.

Course Approval: The course has been approved by the Department of Inspections and Appeals and is available from Program in Health Occupations Education, The University of Iowa, N487 Lindquist Center, Iowa City, IA 52242-1529. Phone: 319/335-5316.

Course Teachers: Course teachers must be state approved (Board of Educational Examiners) teachers or must complete the approved teacher trainer program and be certified as nurse aide teachers.

Materials and Texts: Each college/facility will determine the text that will be used. Students will be given text assignments prior to the class when content is discussed. Handouts available from Program in Health Occupations Education, The University of Iowa, N479 Lindquist Center, Iowa City, IA 52242.

Methods of Teaching the Course: Lecture, discussion, film strips, handouts on special materials, demonstrations, laboratory practice, return demonstrations, role playing, textbook assignments and other appropriate activities will be used to assist the learner in mastering the competencies. A class/laboratory/ clinical schedule shall be developed and shared with students.

Clinical Requirements: A minimum of 30 hours will be scheduled for a supervised clinical experience. The clinical setting shall be a nursing facility and the supervisor shall be the course teacher or their official designee. During this experience students will be assigned to provide care to one or more residents. Clinical evaluations will be completed and reviewed with the students at the completion of the experience.

Evaluation: Students will be given quizzes, unit tests, and must satisfactorily complete skills checklists, receive a satisfactory clinical evaluation, and receive acceptable grade on the course final examination to pass the course. Once the students have successfully completed the course they will be given a certificate of successful completion and will be eligible to take the required written and practical competency examination required by the state for certification.

Credentialing: Nurse Aide Registration is done through the Department of Inspections and Appeals. The competency tests are given at the community colleges and you may obtain a copy of test dates from the Health Occupations Adult Coordinators. Once nurse aides have been registered they must complete inservice training every quarter. If a nurse aide does not work for 24 consecutive months, he/she must retake an approved nurse aide course and/or retake and successfully pass the written and skills competency tests.

Course Developers: Program in Health Occupations Education
The University of Iowa in cooperation with
Iowa Department of Education
Course Coordinator - Joyce Brandt, R.N. Ph.D.
Revision Writer - Judy Theisen, R.N., B.S.

COMPETENCIES FOR 75 HOURS NURSE AIDE COURSE

Communicates effectively with residents/patients, health facility staff and resident/patient family/visitors.

1. Uses correct medical terminology and abbreviations.
2. When required, answers telephone properly.
3. Records and reports pertinent observations related to resident/patient procedures and conditions.
4. Reports and records procedures accurately.
5. Records/reports intake and output.
6. Listens effectively.
7. Communicates effectively with residents/patients with hearing/seeing disabilities.
8. Communicates effectively with residents with cognitive impairment.
9. Uses therapeutic communications when required - cuing, validation therapy.

Interacts appropriately with residents/patients, health facility staff and resident/patient family/visitors.

1. Uses the philosophy of restorative/rehabilitation when providing care.
2. Identifies basic emotional needs.
3. Identifies basic changes in normal growth and development and applies in care situations.
4. Identifies the physical/social/emotional changes that occur in elderly and chronically ill.
5. Differentiates between the care needs of the acutely and chronically ill.
6. Identifies the special needs of residents/patients with disabilities, including physical problems, mental illness, mental retardation, and dementias.
7. Encourages resident/patient to be as independent as possible.
8. Respects and defends resident rights.

Uses ethical/legal principles in providing care and fulfilling job responsibilities.

1. Describes various types of care facilities.
2. Differentiates between various types of health care facilities and their administrative structure.
3. Identifies the relationship between various governmental and private agencies that provide guidelines for resident/patient care.
4. Identifies roles of various health care personnel within facilities especially the role of the nurse aide.
5. Demonstrates responsibility concerning resident/patient rights.
6. Practices confidentiality.
7. Recognizes ethical responsibilities.
8. Follows institutional policies and procedures.

Practices safety measures in providing resident/patient care.

1. Uses correct hand washing techniques.
2. Uses CDC guidelines (universal precautions) in providing care.
3. Maintains a safe, clean environment.
4. Uses correct body mechanics.
5. Follows emergency procedures for fire and other disasters.

6. Provides emergency care for choking resident/patient.
7. Positions resident/patient's call light within reach.
8. Promotes a restraint free environment and when necessary properly and safely applies restraints.

Uses information on care plan to assist the resident/patient with personal hygiene.

1. Bathes resident/patient or assists with bathing.
2. Assists resident/patient with tub bath/shower/whirlpool.
3. Performs perineal care.
4. Performs or assists with oral hygiene including mouth and denture care.
5. Performs a resident/patient back rub.
6. Applies care for a resident/patient's nails.
7. Assists with or shaves resident/patient.
8. Assists resident/patient with dressing/undressing.
9. Assists resident/patient with hair care.
10. Assists resident/patient with adaptive devices, including sensory devices.
11. Assists resident/patient with nutritional needs (special diets).
12. Feeds resident when needed.
13. Makes occupied and unoccupied bed.

Performs special procedures for the resident/patient.

1. Provides for resident/patient privacy.
2. Positions resident/patient in correct body alignment.
3. Transports resident/patient, using correct equipment.
4. Assists resident/patient in standing and ambulating.
5. Observes and maintains urinary drainage system.
6. Assists resident/patient with bladder/bowel training.
7. Assists resident/patient with elimination needs.
8. Measures and records temperature, pulse, respiration and blood pressure.
9. Uses techniques that help prevent pressure sores.
10. Performs passive range of motion.
11. Directs active range of motion.
12. Measures and records resident/patient height and weight.
13. Identifies the five steps of approaching death or reactions to approaching death.
14. Explains the procedure for post-mortem care.
15. Identifies ways to ease the impact of loses.
16. Applies anti-embolism elastic stockings.

VALIDATION OF PERFORMANCE SKILLS IN 75 HOURS NURSE AIDE COURSE

Following is the criteria for assess the Nurse Aide student's level of achievement of the above competencies.

1. Skills will be validated on individual skills checklist which will be completed either in the laboratory or clinical area. The level of achievement for each student will be documented on the summary competency sheet, which identifies students level of achievement.

   Skills checklist will be completed on the following skills:

   1. Handwashing
   2. Making a closed/open bed.
   3. Making an occupied bed.
   4. Providing emergency care for conscious and unconscious choking victim (referred to as Heimlich Maneuver).
   5. Safely applying restraints.
   6. Using mechanical lift/sling for transferring resident.
   7. Lifting/moving/positioning resident in bed.
   8. Applying and using a transfer belt.
   9. Transferring resident from bed to chair or from chair to bed.
   10. Positioning resident in bed.
   11. Assisting the resident with ambulation.
   12. Assisting with passive/giving active range of motion.
   13. Providing/assisting with oral hygiene, with and without dentures.
   14. Giving a partial bath.
   15. Giving a complete bed bath.
   16. Providing perineal care.
   17. Assisting with whirlpool bath.
   18. Assisting with tub bath/shower.
   19. Giving a back rub.
   20. Assisting with or giving a shampoo.
   21. Assisting with or providing nail care.
   22. Assisting with dressing/undressing.
   23. Assisting with shaving.
   24. Assisting the resident to use the urinal.
   25. Assisting the resident to use the bedpan/commode.
   26. Preparing a resident for meals/feeding resident.
   27. Obtaining accurate vital signs, TPR.
   28. Obtaining accurate blood pressure.
   29. Obtaining the resident's height and weight.
   30. Measuring and recording intake and output.
   31. Obtaining routine urine sample.
   32. Providing daily catheter care.
   33. Communication

2. The cognitive learning objectives will be assessed by written tests. A student must achieve the passing score identified by the institution providing the program. This will demonstrate minimum successful completion on the principles/procedures portion of the course.

3. A clinical evaluation will be used to document the student's ability in applying the knowledge, performing the skills and displaying attitudes required of the nurse aide.

Following are the standards for successful completion of the course:

Standard for successful completion will be determined by each institution that provides the course and will be given to students in writing on the first day of class.

NURSE AIDE COURSE

OUTCOMES Knowledges - skills and attitudes regarding	ASSESSMENT Assessment of Outcomes
1. Basic functions of nursing facilities	Written items
2. Staff working in nursing facilities and their role - interdisciplinary	Written items
3. Types of facilities and administrative structure	Written items
4. Role of nurse aide - communications	Written items/clinical
5. Legal and ethical considerations - resident's rights - restraint appropriate	Written
6. Communications and interpersonal skills	Written Items Skills Test Clinical
7. Philosophy of restoration/rehabilitation Encouragement of self care	Written and skills
8. Physical/social/emotional changes that occur in elderly and chronically ill	Written
9. Caring for residents with special needs, common physical problems, dementias, mental illness, mental retardation	Written items/clinical
10. Infection control/universal precautions Handwashing/medical asepsis	Written, skills, and clinical
11. Safety emergency precautions Disaster and choking resident	Written/skills
12. Basic dietary requirements	Written/skills
13. Modified diets	Written
14. Death and dying - needs of resident/family	Written
15. Care of resident with artificial eyes, limbs, hearing aids, other prosthetics	Written
16. Observe/report changes in resident's condition	Written and clinical
17. Use information included on care plan for giving resident care	Written and clinical
18. Maintain resident's environment	Written and clinical

OUTCOMES	ASSESSMENT
19. Making occupied/unoccupied bed	Written and skills
20. Use of safety precautions a. preventing falls b. preventing burns c. fire precautions d. oxygen precautions	Written
21. Awareness of restraint - applications when appropriate	Written and Skills checklist
22. Transferring residents (wheel chair/stretcher, etc.) Ambulation - gait belt	Written and Skills checklist
23. Positioning and maintaining resident's position in bed	Written and Skills checklist
24. Active/passive range of motion	Written and Skills checklist
25. Oral hygiene (dentures included)	Written and Skills checklist
26. Bed bath--complete and partial (perineal care)	Written and Skills checklist
27. Tub/shower care	Written/clinical
28. Dress/undress resident - use artificial devices	Written/clinical
29. Grooming - Hair care, shaving, nail care	Written and Skills checklist
30. Elimination needs - bedpan/urinal	Written and Skills checklist
31. Prevention of pressure sores	Written
32. Back rubs	Written and Skills checklist
33. Prepare residents for meals	Written and Skills checklist
34. Feed residents	Written and Skills checklist
35. Obtaining and recording temperature	Written and Skills checklist
36. Obtaining and recording pulse, respiration	Written and Skills checklist

OUTCOMES	ASSESSMENT
37. Blood pressure	Written and Skills checklist
38. Calculate and record I & O	Written and Skills checklist
39. Collect and label specimen (urine only)	Written and Skills checklist
40. Obtain height and weight	Written and Skills checklist
41. Emptying urinary cath beg	Written and Skills checklist
42. Catheter care	Written and Skills checklist
43. Bowel and bladder training	Written and Skills checklist
44. Application of antiembolism stockings	Written

Unit 1 Introduction to the Role of the Nurse Aide

Overview: This unit introduces the aide to the role and function of nursing facilities, to the personnel who provide resident care, to the role of the aide, to effective methods to communicate, and to legal and ethical considerations for those who work in nursing care and skilled facilities.

Suggested Teaching Time: 5-6 Hours

OBJECTIVE	CONTENT	METHOD
1.0 Discuss the purpose of a nurse aide course.	I. Nurse aide course	
	A. Purpose of course	Handout "Nurse Aide Text" Curriculum
1.1 Identify the methods and course requirements that will be utilized in the teaching and learning competencies.	B. Competencies/skills to be mastered	
	C. Teaching/learning methods used	Lecture/discussion
	1. Textbook	
	2. Audio-visual (videos, films, slides)	
	3. Handout literature	
	4. Skills/technique checklist	
	5. Clinical practice/experience	
	6. Written tests - passing scores	
	7. Discussion/lectures	
	D. Nurse Aide Registry - Iowa Department of Inspections and Appeals	
	1. Requirements to work in LTC	Handout Registry and Inservice Requirements
	2. Written competency tests	
	3. Skills competency tests	
	4. Oral competency tests	
	5. Registry procedures	
1.2 Describe structure and classifications of health care facilities.	II. Health care facilities	Lecture/discussion
	A. Health care facilities encompasses facilities at levels of care of:	
	1. Acute	
	2. Chronic	
	3. Hospice	
	4. Respite	
	5. Rehabilitative/restorative	
	B. Classifications	
	1. Residential (RCF)	
	2. Nursing facilities (NF)	
	3. Skilled Nursing Facility (SNF)	
	4. Acute (hospital-based)	

Overview: This unit introduces the aide to the role and function of nursing facilities, to the personnel who provide resident care, to the role of the aide, to effective methods to communicate, and to legal and ethical considerations for those who work in nursing care and skilled facilities.

OBJECTIVE	CONTENT	METHOD
	C. Promote 'Quality of Life' 1. Promote dignity, self-esteem, physical, psychological, social well-being 2. Provide activities to meet interests a. Church services b. Other 3. Environment a. Home-like atmosphere b. Safe 4. Discussed further under Resident's Rights D. Structure/organization 1. Board of directors 2. Administrative board 3. Auxiliary services a. Nursing b. Professional c. Physical/general d. Administrative 4. Education/committees a. Inservice 12 hours for nurse aide based upon performance evaluation b. Performance evaluation at least once every 12 months c. Staff education d. Resident/family education e. Quality assurance f. Employee/human resources	
1.2.1 Identify the governing bodies, and their role in monitoring and defining the care health care facilities provide.	E. Federal/State Depts. 1. OBRA - HCFA 2. State Boards of Nursing 3. Boards of Health Care Admin. 4. Dept. of Inspection and Appeals 5. Long Term Care Omnibus 6. Care Review Committees	

Overview: This unit introduces the aide to the role and function of nursing facilities, to the personnel who provide resident care, to the role of the aide, to effective methods to communicate, and to legal and ethical considerations for those who work in nursing care and skilled facilities.

OBJECTIVE	CONTENT	METHOD
	7. Protection Advocacy 8. OSHA	
1.3 Discuss the characteristics of individuals in health care facilities.	III. Characteristics of residents - Erickson A. Developmental tasks 1. Integrity and despair 2. Fears - despair a. Death b. Regret for loss of opportunities 3. Ego integrity B. Level of functional capacity 1. Dependent 2. Assistive 3. Independent C. Level of health/illness 1. Chronic 2. Acute 3. Rehabilitative 4. Terminal D. Physically challenged E. Mentally challenged	Text assignment Lecture/discussion
1.3.1 Identify five components that promote health.	F. Quality/Health 1. Promotion of health and prevention of illness 2. Diagnosis and treatment 3. Providing physical/emotional care 4. Maintaining functional capacity and restoring to optimal functioning capacity 5. Provide individual with safe and therapeutic environment	
1.3.2 Review and discuss how aging and illness affect the major systems of the body.	G. Systems change/alteration in conditions 1. Body systems affected a. Skin 1) Hair thinning, greying 2) Skin dryness, wrinkles and loss of natural oils	Role Play/discussion on how to work with residents with compromised/decreasing functions of the major systems

Overview: This unit introduces the aide to the role and function of nursing facilities, to the personnel who provide resident care, to the role of the aide, to effective methods to communicate, and to legal and ethical considerations for those who work in nursing care and skilled facilities.

OBJECTIVE	CONTENT	METHOD
	3) Fingernails/toenails thicken 4) Skin layer thins - susceptible to pressure sores b. Bones and muscles 1) Muscle loss, tone and strength 2) Joints less flexible/loss of dexterity 3) Bones - brittle (osteoporosis) 4) Sense of balance diminishes 5) Degeneration of joints/spine c. Nervous system 1) Decrease in sense of taste, hearing, vision 2) Visual field changes, decrease adaptability 3) Decrease in pain threshold/sensitivity 4) Memory changes/better recall for past d. Digestive 1) Tooth loss/problems chewing 2) Slowed digestion 3) Food intolerances 4) Constipation e. Heart and lung 1) Blood vessels/narrowing and fragile 2) Heart muscle--reduced strength/output 3) High blood pressure 4) Lungs--prone to respiratory infections	
1.3.3 Discuss the mental and emotional adjustments a resident experiences.	2. Adjustments a resident experiences a. Compromised level of wellness/health b. Dependency--emotional and financial c. Loss of autonomy/decision-making d. Peer group change "new one" e. Guilt/burden f. Apathy/pity g. Declining function h. Sense of privacy i. Awareness of mortality j. Changes--death of mate/friends	

Overview: This unit introduces the aide to the role and function of nursing facilities, to the personnel who provide resident care, to the role of the aide, to effective methods to communicate, and to legal and ethical considerations for those who work in nursing care and skilled facilities.

OBJECTIVE	CONTENT	METHOD
	k. Loneliness l. Hopelessness m. Societal prejudice	
1.3.4 Describe the nurse aide's role in dealing with the adjustment process.	3. Adjustment period a. Basic care needs 1) Hygiene 2) Nutrition 3) Sleep/rest 4) Personal space 5) Safety b. Emotional needs 1) Sense of belonging 2) Respect - privacy 3) Understanding 4) Acceptance 5) Self-worth 6) Independence c. Life-style needs 1) Maintenance of body functioning 2) Rehabilitation 3) Socialization 4) Sexuality 5) Livelihood	
	H. Needs of the nursing facility resident 1. Basic needs a. Food, shelter, safety needs 2. Emotional needs a. Belonging, love, achievement, self-esteem	Maslow's Hierarchy
1.3.5 Recognize special needs and qualities of residents.	I. Needs and Qualities 1. Physical/emotional needs are the same as other residents 2. Rehabilitative/restorative treatments/ therapies 3. Appropriate cognitive level activities	Lecture/discussion

Overview: This unit introduces the aide to the role and function of nursing facilities, to the personnel who provide resident care, to the role of the aide, to effective methods to communicate, and to legal and ethical considerations for those who work in nursing care and skilled facilities.

OBJECTIVE	CONTENT	METHOD

4. Appropriate physical level activities
5. Use of adaptive devices
   a. Eating utensils
   b. Personal care items
   c. Bathroom accessories
   d. Ambulation devices
   e. Hearing aids
6. Prosthesis
   a. Eye
   b. Extremities
   c. Other

J. Residents characteristics
1. Physically challenged
   a. Paraplegic
   b. Severe arthritis
   c. Blind
   d. Amputee
   e. Seizures
   f. Deaf
2. Mentally challenged
   a. Dementias
   b. Mental Illness (MI)
   c. Mentally Retarded (MR)
   d. Alzheimers
3. Terminal illness
   a. AIDS
   b. Organ/systems fail
   c. Other
      1) Congestive heart failure
      2) Cancer
      3) Infections
      4) Multiple illnesses

Overview: This unit introduces the aide to the role and function of nursing facilities, to the personnel who provide resident care, to the role of the aide, to effective methods to communicate, and to legal and ethical considerations for those who work in nursing care and skilled facilities.

OBJECTIVE	CONTENT	METHOD
1.4 Describe the roles of the nursing home and health workers involved in care of nursing facility resident.	IV. Role of health care member A. Support/benefits of nursing facility 1. Maintenance 2. Restorative/rehabilitative 3. Safety 4. Opportunities for socialization 5. Provides relief for family B. Interdisciplinary Team 1. Definition - group of individuals whose expertise provide/fulfill needs of a resident 2. Medical Director 3. Registered Nurse 4. Licensed Practical Nurse 5. Support nursing staff a. Nurse Aides b. Medication Aides c. Restorative/Rehabilitation Aide 6. Others a. Social workers b. Physical Therapist c. Food service worker d. Consultant Dietitian e. Unit/ward clerk f. Activity Coordinator g. Occupational Therapist h. Speech Therapist i. Consultant Audiologist j. Consultant Dentist k. Consultant Pharmacist l. Nurse Practitioner m. Physician's Assistant n. Psychiatrists o. Volunteers - peer group	Lecture/discussion

Overview: This unit introduces the aide to the role and function of nursing facilities, to the personnel who provide resident care, to the role of the aide, to effective methods to communicate, and to legal and ethical considerations for those who work in nursing care and skilled facilities.

OBJECTIVE	CONTENT	METHOD
	p. Religious personnel q. Practicum students	
1.4.1 Investigate the role of the nurse aide in the nursing care facility. 1.4.2 List the competencies the nurse aide should have to safely do his/her job.	V. Role of the nurse aide A. Support residents to fulfill daily living needs (ADL) 1. Dress 2. Personal hygiene a. Oral hygiene b. Bathing c. Grooming 3. Elimination needs a. Providing urinal/bedpan/ toilet facilities b. Bladder/bowel training 4. Nutritional a. Prepare for meals b. Assist to eat/feed when necessary c. Offer/provide fluids periodically d. Observe nutritional adequacy/habits e. Weights/heights f. Intake/outputs 5. Safe environment a. Knowledge of fire/accident prevention and procedures b. Prevention strategies (fall/burns) c. Equipment used and stored properly d. Protect from injury to self/ or from others 6. Assist the resident with activity needs a. Transferring/lifting/walking b. Range of motion - active/passive c. Positioning/repositioning d. Daily exercise regime	Textbook Assignment Job description from facility Rules and regulations regarding resident care Filmstrip: "Being a Nurse's Aide" List of competencies from curriculum (handout) Lecture/discussion

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Overview: This unit introduces the aide to the role and function of nursing facilities, to the personnel who provide resident care, to the role of the aide, to effective methods to communicate, and to legal and ethical considerations for those who work in nursing care and skilled facilities.

OBJECTIVE	CONTENT	METHOD
	7. Assist resident with orthotic/assistive devices a. Walker, cane or crutches b. Transfer (gait) belts c. Dressing/eating devices d. Artificial limbs, adaptors, eyes e. Braces, back brace or extremity splints f. Hearing aids g. Restraints 8. Support/provide/encourage socialization activities a. Recreational activities b. Social activities/interaction 9. Monitor what is happening with the resident a. Emotionally/socially b. Physically/mentally 10. Report and record as required a. Physical/mental status of resident changes b. Pain c. Intake/output/TPR/weight/stools/urine amounts/color d. Other unusual conditions/reactions	
1.4.3 List some activities a nurse aide is <u>not</u> prepared to do.	11. Identify skills and tasks a nurse aide may <u>not</u> perform a. All skills/tasks not checked to competency - or not taught b. Administer medications/treatment c. Any skill/task not included in competency list	
1.5 Identify desirable characteristics of the nurse aide.	VI. Nurse aide qualities A. Personal appearance/dress B. Personal hygiene C. Healthy physically and mentally	Text assignment Lecture/discussion

Overview: This unit introduces the aide to the role and function of nursing facilities, to the personnel who provide resident care, to the role of the aide, to effective methods to communicate, and to legal and ethical considerations for those who work in nursing care and skilled facilities.

OBJECTIVE	CONTENT	METHOD
	D. Dependability 1. Work hours scheduled and contracted to work 2. Provide complete resident care needs 3. Works according to job description E. Follows rules and regulations 1. Dress code 2. Substance/chemical abuse 3. Personal phone calls, mail and visitors 4. Absence from work and notification 5. Smoking and eating F. Interpersonal relations with co-workers	
1.6 Describe the aide's legal/ ethical responsibilities.	VII. Legal/Ethical Responsibilities A. Ethical responsibilities 1. Definition - A moral guide 2. Respect for residents and property 3. Loyalty 4. Treating others as you would like to be treated 5. Non-judgmental B. Legal Responsibilities 1. Definition - Act according to law 2. Confidentiality a. Breech of confidentiality 1) Talks about one resident with another resident 2) Talks to relatives and friends about a resident 3) Discusses a resident with visitors 4) Discusses a resident with news media 5) Gossips about resident with other staff members 6) Talks about resident with friends b. Consequences of abusing confidentiality	Text assignment Handout on "Ethics" Trainex: "Professional Ethics for Nurse Assistant" Handout on Resident's Rights 16 Hour video content

Overview: This unit introduces the aide to the role and function of nursing facilities, to the personnel who provide resident care, to the role of the aide, to effective methods to communicate, and to legal and ethical considerations for those who work in nursing care and skilled facilities.

OBJECTIVE	CONTENT	METHOD
	3. Negligence a. Performing tasks not prepared to do b. Performing procedures incorrectly/ unsafely c. Not cleaning up spills or being careless with materials that cause harm/dangerous d. Other acts that cause injury/ compromise a resident's condition	
	4. Mandatory reporting of Dependent Adult Abuse a. Definition of dependent adult b. Definition of abuse c. Reporting requirements d. Training requirements	Does not meet requirements for mandatory reporting Handout, rules and regulations
1.6.1 Describe nurse aide's role in promoting/protecting resident's rights.	5. Resident Rights a. Protected by state/federal laws b. Residents must be informed of these rights c. Protects dignity, self-respect, and quality of life d. Specific rights 1) Privacy and confidentiality a) Preventing unnecessary exposure b) Use screens/shut doors c) Visit privately d) Send and receive mail 2) Personal choice a) Physicians b) Activities and schedules c) Planning own care 3) Grievances a) Express concern regarding care/ treatment b) Cannot be punished	Handout "Resident Rights" Rules/regulations

Overview: This unit introduces the aide to the role and function of nursing facilities, to the personnel who provide resident care, to the role of the aide, to effective methods to communicate, and to legal and ethical considerations for those who work in nursing care and skilled facilities.

OBJECTIVE	CONTENT	METHOD
	4) Care and security of personal possessions a) Use of personal property b) Personal property treated with respect 5) Freedom from abuse/mistreatment a) Policies to protect b) Cannot hire employees accused of abuse in past	
1.7 Discuss the importance of effective communications.	VIII. Communications A. Types 1. Verbal 2. Nonverbal 3. Written B. Successful communication involves a 1. Message 2. Sender 3. Receiver C. Nonverbal communications 1. Facial expression 2. Tone of voice 3. Body posture/gestures	Text assignment Lecture/discussion Role play activity - selected by instructor
1.7.1 Describe the importance of listening as part of communication.	D. Listening - a part of communication E. Verbal Communication 1. Accurate and clear 2. Types a. Person to person b. Oral report 3. Communicating on the phone a. Answering the phone b. Identifying facility, person c. Courteous d. Message--written	

Overview: This unit introduces the aide to the role and function of nursing facilities, to the personnel who provide resident care, to the role of the aide, to effective methods to communicate, and to legal and ethical considerations for those who work in nursing care and skilled facilities.

OBJECTIVE	CONTENT	METHOD
1.7.2 Assist the resident who has impaired hearing/sight/or speech.	4. Communication with residents with decreased hearing a. Face resident b. Tone of voice c. Speech speed d. Write when necessary e. Courteous good-bye f. Hearing aids 1) Uses 2) Application	Getting Through, record on hearing aids Handout on "Hearing Aids"
	5. Decreased sight a. Eye diseases 1) Medication 2) Glasses 3) Artificial eye b. Use large print c. Give verbal directions d. Explain step by step what you want	 Handout on "Artificial Eyes"
	6. Speech impairments a. Face resident b. Allow time/patience c. Assistive devices d. Writing boards	
1.7.3 Use your senses to make meaningful observations.	F. Observing and reporting 1. Methods of observing a. With the eyes 1) Rashes 2) Swelling 3) Drainage, cuts, burns or bruise b. Touch 1) Change in pulse 2) Dampness of skin, etc. 3) Temperature of skin c. Hearing 1) Wheezing breathing	Lecture/discussion Text assignment

Overview: This unit introduces the aide to the role and function of nursing facilities, to the personnel who provide resident care, to the role of the aide, to effective methods to communicate, and to legal and ethical considerations for those who work in nursing care and skilled facilities.

OBJECTIVE	CONTENT	METHOD
	2) Resident complaints 3) Choking/coughing d. Smelling 1) Odor of breath, wounds, stools or urine 2) Body odors 2. What to report	
1.7.4 State methods to increase observational skills through communications.	G. Using communication skills that increase observations 1. Provide enough time for resident to express self a. Listen carefully/patiently b. Observe nonverbal 1) Body position 2) Facial expression 3) Amount of eye contact 2. Be an empathetic listener a. Eye contact b. Appropriate questions c. Follow-up questions for clarification d. Residents concerns/problems are real e. Touch/hand contact 3. Listen to tone of voice--way said 4. Facilitate relationships a. Don't criticize other staff b. Help resident clarify c. Don't deny resident's feelings	Lecture/discussion
1.7.5 List critical situations when supervisor must be notified immediately.	H. Notify supervisor immediately when 1. Resident complains of severe pain 2. Resident has difficulty breathing 3. There is a sudden change in resident's mental or physical status 4. The resident has an accident/injury 5. Whenever in doubt	Lecture/discussion

Overview: This unit introduces the aide to the role and function of nursing facilities, to the personnel who provide resident care, to the role of the aide, to effective methods to communicate, and to legal and ethical considerations for those who work in nursing care and skilled facilities.

OBJECTIVE	CONTENT	METHOD
1.7.6 Recognize individual differences that affect communication.	I. Factors that can affect individual communications 1. Family problems 2. Money problems 3. Unusual surroundings 4. Pain, fear, shyness 5. Change in environment 6. Personality types	Text assignment Lecture/discussion
1.8 Establish meaningful relations with residents and staff.	J. Developing relationships with residents/ staff 1. Self understanding a. Needs of all human beings b. Your reactions/feelings and how they affect others c. Your values and how values affect behavior 2. Effective communication a. Factors that promote 1) Courteous manner 2) Professional 3) Keep emotions under control 4) Empathetic, tactful 5) Answer resident's call signal promptly 6) Avoid slang 7) Speak clearly and in adequate tone 8) Appropriate grammar 3. Socialization between residents a. Introductions b. Encouragement - introduce topics - stay with for a while - during early stages	

Overview: This unit introduces the aide to the role and function of nursing facilities, to the personnel who provide resident care, to the role of the aide, to effective methods to communicate, and to legal and ethical considerations for t those who work in nursing care and skilled facilities.

OBJECTIVE	CONTENT	METHOD
1.8.1 Discuss factors that promote good relationships with resident's family and friends.	4. Family a. Emotional support - listen to concerns b. Encourage visiting/interaction c. Patience/kindness d. Assist when taking out 5. Visitors and friends a. Treat as a visitor in your home b. Give directions when needed c. Process when visitors take residents out d. Refer to right person for information about resident e. Maintain confidentiality	Maslow's Hierarchy in relation to family meeting levels of belonging, love and achievement. Handouts: Institution's rules concerning visitors

6/92 kjb
1/93 kjb
7/93 kjb

Unit II WORKING ENVIRONMENT

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

Teaching Time: 12-15 hours

OBJECTIVE	CONTENT	METHOD
2.0 Examine the resident's environment and describe the nurse aide's responsibility in maintaining a safe environment.	I. Resident's environment A. Definition B. Role of aide in safety	Text assignment Lecture/discussion
2.1 Define medical asepsis. Discuss three reasons that medical asepsis is important.	II. Medical asepsis A. Definition B. Reason for practicing medical asepsis 1. Micro-organisms are always present in the environment - some normal 2. Some micro-organisms can cause illness in certain people 3. Reducing the number of micro-organisms and hindering their transfer increases the health of the environment	Text assignment Lecture/discussion <u>Universal precautions reference for Instructions on Infection Control</u> - handout Trainex: "Medical Asepsis"
2.1.1 Describe the nature of micro-organisms.	C. Nature of micro-organisms 1. Disease producing micro-organisms are called pathogens 2. Ways spread a. Direct contact b. Indirect contact - droplets c. Flies, mosquitos, ticks, food d. Air borne e. Vehicle - vectors 3. Types of micro-organisms a. Bacteria b. Virus 4. Pathogens a. Grow best at body temperature b. Destroy human tissue by using it as food c. Give off waste products that are called toxins d. Toxins poison the body	Lecture/discussion Text assignment

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	5. Staph (staphylococcus) and strep (streptococcus) are two types of a bacteria (pathogens) that are found in all health care facilities 6. Virus is another form of micro-organism	
2.1.2 List the six conditions that affect the growth of bacteria.	D. Conditions that affect/promote the growth of bacteria 1. Food 2. Moisture 3. Temperature 4. Oxygen 5. Light 6. Dead and living matter 7. Waste products 8. Improper isolation procedures 9. Poor hand washing	Text assignment
2.1.3 Discuss the two methods used to kill micro-organisms or keep them under control. a. Disinfection	E. Disinfection 1. Process of destroying harmful organisms 2. Slowing growth and activity of the organisms	
b. Sterilization	F. Sterilization 1. Definition 2. When necessary a. Surgery b. Wounds c. Certain procedures e.g., catherization	
2.1.4 Define terms reinfection and cross infection and describe methods to prevent.	G. Reinfection 1. Infected a second time 2. Prevented when medical asepsis used	Lecture/discussion
	H. Cross infection 1. Infected by micro-organisms from another resident or member of the staff 2. Always wash hands between giving cares 3. Always clean equipment after use with a disinfectant	

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
2.1.5 Identify some of the practices that you as an aide can do to demonstrate your practice of medical asepsis.	I. Role of aide in medical asepsis 1. Cleaning the resident's unit 2. Washing your hands 3. Cleaning all reusable equipment after use 4. Disposing of contaminated articles correctly 5. Cleanliness of self and/or resident 6. Cleanliness of resident's equipment; e.g., bathtub, whirlpool, etc. 7. Sterilizing equipment, when needed 8. Cleanliness to control disease	Lecture/discussion
2.2 Demonstrate the competency of safe handwashing. 2.2.1 Identify and discuss the reasons for good handwashing.	III. Handwashing A. Reasons for thorough handwashing 1. Everything you touch has germs on it 2. Use hands constantly 3. You carry germs from resident to resident, your constant adherence to good hand washing prevents this transfer 4. You must wash your hands before and after each contact with every resident, for resident's protection and your own	Text assignment
2.2.2 Discuss the rules to follow regarding handwashing that demonstrate your understanding of medical asepsis.	B. Rules to follow regarding handwashing 1. Always wash your hands a. Before contact with each resident b. After contact with each resident 2. Handwashing is only effective when: a. You use enough soap to produce a lot of lather b. Friction--vigorous rubbing removes micro-organisms c. Rinse from the clean to dirty. Elbows (clean) to finger tips (dirty) d. Rinse with hands down 3. Hold your hands lower than your elbows while washing 4. Add water to the soap while washing	Lecture/discussion

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	5. It is recommended aides not use resident's soap 6. Rinse/dry your hands well after washing	
2.2.3 List steps for proper handwashing techniques.	C. Procedure - Handwashing 1. Assemble equipment. Each sink at care facility should be equipped with: a. Dispenser soap b. Paper towel c. Warm running water d. Wastebasket	Return demonstration
2.2.4 Demonstrate proper handwashing techniques.	2. Completely wet your hands 3. Apply soap 4. Hold hands lower than elbows 5. Work up a good lather 6. Clean your nails 7. Using a rotating and rubbing motion, rubbing palm of hand including between fingers for minimum of 15 seconds 8. Wash at least two inches about wrists 9. Rinse well 10. Dry thoroughly with paper towel - discard 11. Turn faucet off with dry paper towel 12. Discard paper towel in waste basket	Skills Checklist #1 - Handwashing Technique
2.2.5 Observe universal precaution techniques when providing resident care.	D. Universal precautions 1. Definition 2. Purpose 3. Requirements a. Handwashing - before gloving and after removing gloves b. Glove when in contact with body fluids with visible blood c. Urine, blood, feces, rectal temperature. collecting specimen d. If nicks, cuts, sores on hands - gloves for all resident contact	

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	e. Gowns in addition to gloves when exposed to procedures in which blood is present	
	f. OSHA requirements 1) Precautions with body fluids 2) Vaccines - hepatitis 3) Housekeeping	Handout--"OSHA"
2.3 Discuss the purpose of isolation technique.	IV. Isolation A. Isolation technique 1. Definition 2. Purpose 3. Types of isolation 4. Special precautions for protection a. Gloves (latex or vinyl) b. Mask c. Gowns d. Goggles 5. Special precautions are needed to prevent the spread of micro-organisms to other residents and other personnel	Lecture/discussion
2.3.1 Differentiate between contaminated, clean, and dirty.	B. Terminology associated with an Isolation unit 1. Contaminated - any article that is in contact with the resident in the isolation unit is considered contaminated - dirty a. Hands b. Clothes in contact with resident 2. Clean - means uncontaminated a. All articles and places that have not been contaminated with or come into contact with pathogens	
2.3.2 Describe the aide's role in isolation.	C. Aide's role with isolation 1. Process depends on type of isolation 2. Aide needs additional inservice prior to caring for resident in isolation	Lecture/discussion

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
2.4 Describe the resident's room/bath. Briefly list the major items that are usually in a resident's room.	V. The resident's room and bathroom A. Resident's personal possessions 1. Personal possessions - resident identity associated with possessions 2. Help resident keep possessions secure 3. Don't move/use without permission 4. Refer to facility policy regarding marking of possessions, B. Resident's equipment 1. Bed 2. Lamp 3. Overbed table 4. Call signal 5. Bedside table (optional) 6. Lined wastebasket 7. Chair 8. Personal belongings/furniture C. Items for personal bedside care 1. Urinal/bedpan 2. Washbasin/soap dish 3. Emesis basin 4. Personal hygienic supplies--belong only to resident a) Shaving equipment b) Skin lotion/powder c) Tissues d) Toilet tissue e) Toothbrush/denture cup - toothpaste/ mouthwash f) Any personal items used in personal hygiene g) Make-up 5. Towels/washcloth D. Screening curtain for privacy	Text assignment Tour of resident's unit Lecture/discussion See facility procedure book for storage of resident's equipment

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
2.4.1 List seven tasks aides perform in assuring that the resident's unit is safe and completely furnished.	E. Safety practices 1. Call bell in reach 2. Chair positions - locked/low 3. Bedpans/urinals emptied, cleaned and placed according to policy 4. Bedside stand placement 5. Bed in lowest position--always locked 6. Fall precautions a. Spills on the floor b. Items that could be "tripped" over in the room c. Frayed electrical cords - removed/replaced 7. Cleaned/daily restocked 8. Proper storage of caustic/poisonous materials	Lecture/discussion
2.4.2 List the equipment that could be in a resident's unit.	F. Disposable equipment at bedside 1. Equipment made for use of one person 2. Is usually made of plastic, styrofoam or paper 3. Does not need to be sterilized 4. Some items that you may see in resident's unit a. Water pitchers and cups b. Specimen containers c. Urinals/bedpans d. Emesis basins e. Disposable items (briefs, pads) 5. If the disposable equipment is for one person's use, it is cleaned after each use and reused (e.g. urinals, bedpans, etc.) 6. If the item becomes soiled and cannot be cleaned by washing, it is then replaced by by a new disposable item	Text assignment Lecture/discussion

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
2.4.3 Describe the large equipment needed for resident care and treatments that you may see in a nursing facility.	G. Large equipment that is needed for resident care 1. Resident lifts 2. Stretcher 3. Supply tables 4. Bed cradles 5. Walker 6. Wheelchairs 7. IV poles 8. Commodes 9. Crutches 10. Recliner chairs	Examples of large equipment Lecture/discussion
2.5 Discuss the importance of the resident's bed and why the bed needs to be made correctly.	VI. Maintaining resident's bed A. Rules 1. Bed should allow for the greatest comfort a. Older people have less tissue padding over their bones, wrinkles can actually cause pain b. The older resident's skin is very fragile. Wrinkles can constrict circulation resulting in pressure areas. These pressure areas lead to the development of pressure sores 2. A resident needs to be gotten out of bed and encouraged to interact with others, but some residents are unable to be up. With these resident a. All of the activities of daily living are carried out in the resident's bed 1) Bathing 2) Eating 3) Elimination 4) Medical treatments 3. Linens should have no wrinkles and be kept clean - completed bed should be free of wrinkles	Text assignment Lecture/discussion Trainex: "Basic Bedmaking for Patient Comfort and Safety"

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	4. Make one side of the bed completely--then other. Saves time and energy 5. Should be able to complete bedmaking within 15 minutes 6. Incontinent resident's care a. Perineal cleansing b. Clean linen c. Incontinent briefs	
2.5.1 Identify three basic methods for bedmaking.	B. The closed bed 1. Bed made with the top sheet and spread pulled all the way up 2. Closed bed used if the resident is to remain up for most of the day 3. Turn down before resident goes to bed 4. Pillow can be enclosed or left out depending on your institution's policy C. The open bed--mostly used in hospital setting 1. Bed that has the top sheet and spread fan-folded to the bottom of the bed 2. Allows easy access by the resident and when in bed he/she can pull sheet/spread up easily D. The occupied bed 1. Used for a resident that is unable to be out of bed due to illness, etc. 2. The bed is made while the resident is in it 3. Made the same way as the open/closed beds 4. Remove all wrinkles, wrinkles can be very uncomfortable and cause bed sores 5. Keep the side rail elevated on the opposite side that you are working 6. Make one side at a time 7. Make after the resident's bed bath is completed	Text assignment

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
2.5.2 Demonstrate the ability to make a closed and/or open bed.	E. Making a closed and open bed 1. Assemble all linen 2. Remove dirty linen and place immediately in laundry receptacle 3. Wash hands 4. Adjust bed to a raised position that allows for use of good body mechanics 5. Place mattress pad at top of mattress 6. Place bottom sheet - miter top corners of flat sheet 7. If a contour sheet - tuck tightly 8. Place plastic draw sheet - if necessary 9. Cover with cloth draw sheet 10. Place top sheet and blankets with lower edges tucked/mitered 11. For open bed, fan-fold top sheet and spread back to the foot of the bed 12. Put pillow case on the pillow, usihg correct technique. Pillows do not go under your chin 13. Straighten and clean the resident's unit 14. Wash your hands	Skills Checklist #2
2.5.3 Demonstrate the ability to make an occupied bed.	F. Making an occupied bed after resident's bath has been completed 1. Assemble all linen 2. Wash your hands 3. Insure resident's privacy (pull curtain or close door) position bath blanket - remove top linens 4. Tell resident that you will be making his/her bed 5. Lower back rest and/or knee rest until bed is flat. (Check first with your immediate supervisor. Some residents cannot physically tolerate a flat	Skills Checklist #3 Return demonstration

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	position, i.e., breathing difficulties, arthritic condition or swallowing problems) 6. Bed should be at a comfortable height for use of good body mechanics 7. Be sure side rail is elevated on the opposite side of where you'll be working 8. Loosen all linen 9. Cover resident with a bath blanket 10. Check the position of the mattress. Pull it up if necessary 11. Ask resident to turn on his/her side, toward the side rail 12. Fold bottom sheets toward the resident and tuck against his/her back 13. Place clean bottom sheet on the exposed half of the bed using the correct technique 14. Place plastic with draw sheet if needed 15. Raise side rail on your side 16. Go to the opposite side of the bed. Ask and assist resident to roll over the "hump" onto the clean sheets 17. Remove dirty bottom sheets - place in laundry receptacle - never on the floor 18. Pull clean linen through - pull tight to remove wrinkles before tucking it under the mattress 19. Change pillowcase and put pillow under resident's head 20. Remove bath blanket while applying top linen correctly (do not expose resident) 21. Apply blankets and/or spread 22. Position resident comfortably. Elevate back rest and knee rest if needed 23. Place call signal within resident's reach, (clip/attach to bed if able) 24. Straighten and clean resident's unit	

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	25. Wash your hands 26. When making an occupied bed, be observant for any reddened or broken areas on the resident's skin. Back and heel care/rubs can given at this time	
2.6 Discuss the importance of maintaining and promoting resident's safety.	VII. Safety of residents A. Safety in an nursing facility 1. The two most common accidents that result in injury to residents are falls and skin injuries 2. Safety is one of the most important factors in nursing care. The aide must be alert to possible physical dangers and remains always aware of environmental factors that could lead to accidents and harm to the residents 3. Some residents do not understand why some of their activities could be harmful to them 4. Residents who wander off a. Missing resident concerns b. Policy and procedure manual for process to follow	Text assignment Lecture/discussion Trainex: "Safety is a Matter of Vigilance"
2.6.1 Describe resident's physical conditions that increase the possibility of accidents/falls.	B. Physical conditions that increase the possibility of accidents 1. Tremors may be present due to some physical disorders which result in a loss of balance 2. People have difficulty in maintaining their balance when they change positions from lying to standing, due to vascular changes in their blood vessels 3. Visual conditions which have reduced/ decreased visual fields, clearness or depth perception 4. Reflex reaction is slowed in the older resident 5. Mental changes such as confusion and forget-fulness can occur	Lecture/discussion

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	6. Any person 65 years or older is more prone to serious accidents, falls, burns and fractures. 7. Aging process/conditions increase the chances of an accident/fall	
2.6.2 Practice safety precaution by promoting and maintaining a fall-free environment.	C. Preventing falls 1. Constant supervision and observation can reduce residents falls, accidents or injuries 2. Some falls cannot be prevented, but the number of times a resident falls can be decreased by observing safety precautions 3. Some residents have decreased mental ability (confusion) and physical changes (weakness). You need to be alert to the needs for increased supervision/ appropriate placement of belongings 4. Many accidents happen at night. a. Night lights b. Call lights within reach 5. Keep a resident's clothes/personal care needs at appropriate height to prevent stooping or reaching that can cause a loss of balance - result in fall 6. Observe all safety precautions, know how to operate resident lifts, wheelchairs or any other equipment used in the care of the residents 7. Well fitting - low heeled, non-skid soled shoes/slippers should be worn at all times. Be sure shoe laces are tied, straps secured 8. Residents may trip over long bathrobes or night gowns 10. No throw rugs are to be used on the floors 11. Assist resident in and out of bathtub and/ or showers/provide use of hand rails	Role play Lecture/discussion

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	12. All spills should be cleaned up immediately 13. Check all tips on walkers, canes and/or crutches. Loose rubber tips can lead to falls. 15. Shower chairs should be used in showers 16. Raised toilet seats prevent falls	
2.6.3 Prevent residents from burns by practicing safety precautions.	D. Preventing burns 1. Confused residents should not be given hot liquids without assistance. 2. All bath tub water should be checked with a thermometer before allowing resident to get in - temp should be between 105-115 3. All residents in bath tubs or showers should be observed the entire time to prevent the turning on of the hot water faucet and accidental scalding. 4. If a resident smokes, a large deep ashtray is best to use. If person is confused or has vision problems, supervision is needed at all times when resident is smoking. 5. Any equipment that produces heat should be checked for functioning properly before applying 6. Protective coverings should be used over heating pads, hot/cold packs before being placed next to the skin 7. An order from a supervisor or a physician's order is necessary for application of hot/cold packs	Lecture/discussion
2.6.4 Discuss the emergency treatment	E. Dealing with choking resident 1. Causes a. Possible at any time b. Physiological changes that lead to choking 1) Decreased gag reflex 2) Dentures--don't chew food properly	Handout: Conscious/unconscious choking victim from Iowa Dept. of Public Health, Emergency Medical Services

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	3) Decreased cough reflex c. Causes--food or other objects blocking airway d. Result--cannot breathe	
2.6.5 Describe procedure for administering care to choking victim.	2. Emergency care a. What to look for 1) Cannot speak 2) Gasps for air--cannot breathe 3) Panic look 4) Grasps throat with hands 5) Becomes cyanotic (blue) 6) Collapses	Lecture/discussion
2.6.6 Demonstrate proper administration of emergency intervention for choking resident (formerly Heimlich Maneuver).	b. Life threatening--act immediately 1) Ask: "Are you choking?" 2) Determine if resident has "good", "bad" air exchange 3) Stand behind resident--wrap arms around waist 4) Make a fist with one hand and place thumbside against resident's abdomen midline slightly above navel and well below rib cage 5) Grasp fist with other hand 6) Press into resident's abdomen with quick upward thrusts--each thrust should be distinct and delivered with intent to remove obstruction 7) Repeat until foreign body removed or resident becomes unconscious c. Resident becomes unconscious 1) Call 911 for help (activate EMS) 2) Lower to ground 3) Use tongue/jaw, lift to open mouth 4) Perform finger sweep 5) Open airway using head tilt/chin lift 6) Attempt ventilation	Skills checklist #4

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	7) If unsuccessful, reposition and reattempt d. Assisting obese resident 1) Stand behind--arms under armpits 2) Encircle body 3) Position hands same as above 4) Deliver chest thrusts slowly, distinctly e. Supportive actions 1) Comfort other residents 2) Provide emergency unit access 3) Assist as directed	
2.6.7 Describe precautions to maintain skin integrity - health.	F. Precautions to maintain skin - integrity 1. Changes in the condition of body/skin a. Sweat glands decreased activity b. Loss of elasticity in skin c. Skin drier - scaly, thin d. Nails thicken/harder e. Cuts/sores are slower to heal f. Receives less blood flow/slower circulation 2. Activities that further affect skin integrity a. Too frequent bathing with soap robs skin of oils - dryness leads to cracking - scaling skin b. Irritants such as caked powder, urine, feces, or wound/ostomy site drainage c. Direct pressure and/or rubbing during moving may cause a skin burning or bruising d. Positioned in one place too long 3. Prevention/maintaining healthy skin a. Keep skin clean/dry, especially when incontinent b. Reposition residents correctly and gently	

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OBJECTIVE	CONTENT	METHOD
	c. Protective items for the skin 1) Sheepskin 2) Pillows 3) Elbow-heel protectors 4) Foam pads/cushions d. Turn bedridden residents every 2 hrs. assist/encourage all residents every 4 hrs. e. Remind and/or assist residents to shift positions when sitting	
2.6.8 Discuss general rules of safety that apply to nursing facilities.	G. General rules of safety 1. Report immediately to supervisor any unsafe conditions you may notice, i.e., frayed wires, careless smoking, or broken equipment 2. When transporting residents in wheelchairs and/or stretchers, slow down and look when approaching corners or intersections of the hall 3. Pick up any items laying on the floor that resident could fall over. 4. Wipe up spills immediately 5. Always walk in halls. Never run. Use handrails. 6. Be careful of swinging doors/automatic opening doors 7. Check soiled linen for lost or misplaced articles that could harm others; needles, pins, scissors, etc. 8. Be sure to always set the brakes on wheels of shower chairs, stretchers and wheelchairs when transferring residents in and out of these devices 9. Keep side rails elevated for residents per care plan order - i.e., confused, impaired mobility or disoriented resident	Lecture/discussion Always check institutes policy who applies and removes restraints

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OBJECTIVE	CONTENT	METHOD
	10. When ordered, use posey restraints on confused, disoriented residents to insure safety. 11. Never use contents of an unlabeled bottle or one that you question the sterility of, and discard appropriately 12. Keep sharp objects away from residents that could harm themselves or others, crochet hooks, scissors, knives. etc. 13. Always assist residents in bathrooms/to commodes 14. Your work and conduct should reflect safety for the residents, staff and yourself	
2.6.9 Follow facility procedure when accidents/injuries occur.	H. Accident/incident reports 1. Facility policy a. Resident incident b. Nurse aide incident c. Visitor incident 2. Report--written/oral a. Special report forms b. Resident record report	Discussion Policy procedure
2.7 Describe activities for fire safety and prevention.	VIII. Fire safety and prevention A. Fire safety means 1. Preventing fires 2. Knowing and doing the right things if a fire breaks out B. It takes three things to start a fire 1. Any material that will burn 2. Flames and/or sparks 3. Oxygen C. The major causes of fire 1. Smoking and matches 2. Misuse of electricity, frayed wires 3. Defects in heating systems 4. Spontaneous ignition 5. Improper rubbish disposal	Text assignment Lecture/discussion Trainex: "Hospital Fire Safety Procedures","Hospital Fire Hazards" Film: "Code 1001" available from Fire Prevention Through Films, P. O. Box 11, Newton Highland, MA 02161

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	6. Flammable materials, liquids and gases 7. Cooking facilities	
2.7.1 Find and read the facility's fire safety plan.	D. Fire safety plan 1. Know the floor plan of your nursing facility 2. Know all possible exit routes 3. Know the exact location of all fire extinguishing equipment and how to use them a. Fire extinguishers are not all the same. There are four basic types: 1) Dry chemical 2) Carbon dioxide 3) Pressurized water 4) Soda acid b. There are different types for different kinds of fires. Check the cylinder for the type of fire the extinguisher is made for 1) Class A fires - paper, wood, rubbish 2) Class B fires - grease, anesthetics, chemicals 3) Class C fires - electrical fires c. When using extinguisher, direct the material at the base of the fire 4. Know locations of fire alarms and how to use them on 5. Know the emergency evacuation plan of your institution and what you should do during an emergency	Example of fire safety plan for your facility Trainex: "Fire Extinguishing Equipment" Facility's floor plan and position of fire extinguishers
2.7.2 Identify your role as an aide in handling a fire emergency.	E. Handling a fire emergency 1. Things to do in case of fire a. Pull fire alarm at the nearest alarm box b. Shut doors to rooms--do not use elevators c. If the fire is in a resident's area, assist residents to safety	Lecture/discussion

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OBJECTIVE	CONTENT	METHOD
	d. Notify appropriate personnel of exact location and nature of fire e. Follow the emergency plan for your facility f. AVOID PANIC. Many lives could depend on your actions in an emergency	
2.7.3 Discuss the rules for <u>safe</u> smoking that you as an aide must follow and maintain.	F. Rules for safe smoking 1. Unsafe smoking is a major cause of fires. Know the smoking policy and procedures 2. See that large, deep ashtrays are provided and that they are used by residents and staff 3. Observe all no smoking signs. Be on the alert for visitors that disregard such signs. 4. Never empty an ashtray into wastebaskets or containers of rubbish that will burn. Smoking materials should be placed in separate containers. 5. Residents tend to be forgetful at times. Observe all older residents while they are smoking. 6. No resident should smoke in bed <u>EVER</u>. 7. When visitors and other staff are smoking, they should be aware of safety rules. Remind them politely if necessary of the rules. 8. Lighted cigarettes, cigars and pipes should never be carried in hallways 9. No resident that is confused or sedated should be allowed to smoke (without supervision). 10. Be aware of your institution's policies concerning smoking for resident, staff and visitors.	Lecture/discussion Smoking policy of facility

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
2.7.4 List the rules to follow to prevent electrical fires.	G. Electrical fires 1. How started a. Plugging an electrical appliance into a defective outlet b. Using a lightweight electrical cord with heavily powered machinery or appliances c. Failure to notice and report frayed cords, short circuits and loose connections d. Overloading extension cords	Trainex: "How to Identify Electrical Hazards" "Protecting Yourself and Your Patient from Electrical Shock" Lecture/discussion
2.7.5 List the safety precautions for oxygen therapy.	H. Oxygen safety 1. Safety a. All oxygen in portable tanks needs to have a device called a "regulator" which controls flow of oxygen 2. All oxygen in portable tanks have special precautions, follow 3. Each institution has a policy regarding the care of these tanks. Read policy 4. Care of oxygen concentrators a. Moving concentrators b. Ambulating resident 5. Concentrated oxygen can make things start on fire and burn more rapidly than they would in normal air 6. Some residents use oxygen concentrators continuously. Know precautions	
	I. Rules to prevent fires when oxygen is being used a. Electrical appliances should be removed whenever possible b. No smoking in the room by anyone. Remove all smoking materials	Lecture/discussion Oxygen therapy policy of individual facility

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OBJECTIVE	CONTENT	METHOD
	c. Static electricity can cause fires. Any sparks from woolens, etc. should be prevented by humidification d. Oxygen is combustible. All rules of your institution should be followed exactly e. Know process for assisting residents on concentrators 1. Moving concentrator 2. Ambulating resident	
2.8 Describe restraint-appropriate environment.	IX. Restraint appropriate A. Definition of restraints B. Complications of using restraints 1. Resident dignity 2. Loss of control 3. Physical complications C. Philosophy of restraint appropriate D. Nurse aide role 1. Establish good relationship with all residents 2. Recognize individual resident's behavior patterns 3. Observe/report a. Behavior b. Causes of behavior 3. Nurse aide's role	Lecture/discussion Restraint Revisited, Handout from Iowa Foundation for Medical Care
2.8.1 Identify and discuss the methods for protecting/maintaining a resident's personal safety.	E. Preserving resident's personal safety 1. Knowledge of resident's rights and dignity 2. Knowledge of facility's policy and procedure 3. Follow established orders for restraint and restraint-appropriate environment 4. Protection of the resident to prevent injuries, and maintain a resident's safety 5. Guidelines to follow in the application of restraints a. Never apply restraints without a	

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	direct order from your immediate supervisor	
	b. Use the least number of restraints that will protect the resident. Sometimes a posey vest restraint is all that is necessary	Lecture/discussion Skills Checklist #5
	c. The restraint needs to be applied so that the resident's body is in an anatomical position	
	d. Allow resident as much movement as possible but still serving the intended purpose - residents safety and preventing injuries	
	e. Pad bony prominences under a restraint in order to prevent skin trauma/pressure	
	g. Check the resident's extremity every 1/2 hour for symptoms 1) pallor, blueness 2) cold 3) tingling 4) pain 5) pulses must be present If any of these symptoms are present, the restraints must be loosened, and reported to immediate supervisor	
	h. Remove restraints every two hours. Exercise the limb and provide skin care. Ambulate resident if possible, reposition resident	
	i. Never apply a restraint without checking the resident's circulation before leaving the room. Pulses must be felt. Loosen restraints if they are not.	

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OBJECTIVE	CONTENT	METHOD
2.8.2 Discuss and demonstrate the ability to safely apply three types of restraints.	F. Types of restraints 1. Type 1 - Type 2 2. Type 3 - Hand and foot restraints a. Used to keep a limb immobilized b. Wrist and/or ankle is padded with special felt pads. The cloth restraints are then applied by using a clove hitch (which will not tighten when pulled). The ends are then tied to the bed frame. Never attach a restraint to the side rails. 3. Cross over jacket restraints (posey vest) a. Put on like a jacket b. Ends are crossed over in the back or front c. Ends are tied behind wheel chair or on bed frame - not siderails or wheelchair wheels 4. Safety belts a. A variety of models b. Belt goes around resident's waist c. Attaches to a longer belt which is fastened behind wheelchair or on bed frame 5. Mitt restraints a. Used for confused residents that could harm themselves with their hands or fingers, scratch, bite or hit b. A mitt is similar to a paddle that encloses the hands 6. Soft waist restraints a. Used for minimal restraint/secure resident in chairs	Examples of various restraints 1) Hand & foot restraints 2) Posey vest 3) Safety belts 4) Mitt restraints 5) Soft waist restraints 6) Geri chair with tray 7) Divided doors 8) Side rails Skills Checklist #5 Check manufacturer's recommendations Check manufacturer's recommendations for those used in your facility

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OBJECTIVE	CONTENT	METHOD
2.9 Describe methods to safely transport resident. 2.9.1 Demonstrate safety with wheel chairs.	X. Safely transporting residents A. Safety with wheelchairs 1. Resident should be covered to prevent chilling. Blankets should be kept away from wheels. Tuck the blanket firmly around the resident 2. Push the wheelchair from behind except when going in and out of elevators, pull the wheelchair into and out of the elevator backwards. 3. If moving a resident down a steep ramp, you should take the wheelchair down backwards. Glance over your shoulder to be sure of your direction and prevent collisions and possible falls 4. Always set the brakes when: a. Assisting a resident into a wheelchair b. Assisting a resident out of the wheelchair c. When the wheelchair is to remain stationary 5. Always put foot rests up when assisting resident in and out of the wheelchair 6. Always have resident's feet on foot rests. Never attempt to move the wheelchair if the foot rests are in an up position 7. Proper position and attach drainage bags if present 8. If safety straps are needed (e.g., with a resident that can not sit safely by themself be sure they are fastened correctly) 9. Be careful of resident's feet when turning the wheelchair or when going down corridors. Always pay attention where you are going and push the chair slowly. 10. Slow down at corners and look before moving the wheelchair, to prevent collisions with other residents, staff, etc.	Text assignment Trainex: "Patient Safety from Thermometers to Wheelchairs"

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	11. Elderly residents depend on you for their safety a. Never assume that corridors are empty b. Always push the wheelchair slowly to prevent accidents 12. Storage/folding/cleaning wheelchairs. Follow facility policies	
2.9.2 Discuss the safety precautions involved in the operation of portable mechanical lifts to move residents.	B. Safety involved with portable mechanical lifts 1. There are many different kinds of mechanical lifts. Each institution will possibly have a different model. (The safety precautions discussed here will be general information as it applies to all types.) 2. Mechanical lifts are used to move residents from bed to chairs or into whirlpools and baths 3. The mechanical lifts are usually used for residents that can not assist in their own transfer and/or residents that are physically too heavy for the staff to lift safely. Check with supervisory nurse 4. Some models have canvas straps or canvas slings. Refer to your individual facility's type	Text assignment Trainex: "Use of Patient Lifters" Example of mechanical lifter
2.9.3 Demonstrate the safe use of a mechanical lift.	5. General safety rules a. Explain to resident the purpose and function of a mechanical lift b. Follow your facility's policy and procedure for using a mechanical lift c. Reassure residents about lifts safety before and during transfer. Residents are fearful of falling d. Never operate a mechanical lift without the assistance of another knowledgeable	Role play Demonstration of your

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OBJECTIVE	CONTENT	METHOD
	staff person. Safety requires that at least two people are present	facility's mechanical lift, if available.
	e. Lock all brakes after positioning lift	
	f. Be sure that all locks and straps are fastened securely before operating lifter.	Skills Checklist #6
	g. When resident is secured in straps or slings, raise them slowly.	
	h. One person guides the resident's legs in the direction you want to go. Be careful that the legs do not bump into any objects. The other person moves the lifter.	
	i. Protect resident from bumping/scraping at all times.	
	j. Be sure to reassure resident while transferring--often frightened of falling	
2.10 Demonstrate correct method of good body mechanics.	XI. Body mechanics	Text assignment
	A. Muscle skeletal system	
2.10.1 Briefly identify and discuss the normal basic body structures of the skeletal system.	1. The skeletal system is made up of 206 bones	
	a. Act as a framework for the body	Lecture/discussion
	b. Give structure and support	
	c. They (the bones) do not move by themselves. They are moved by muscles, which shorten or contract.	
	d. Tendons and ligaments are supporting structures to the muscle	
	2. There are four types of bones	
	a. Long bones	Charts
	1) Big bone in your thigh, the femur	
	2) Give shape and support to body parts	
	b. Short bones	
	1) The bones in your finger (phalanges)	Diagrams
	2) Give flexibility to the body	
	c. Irregular bones	Example of skeleton
	1) Vertebrae that make up the spinal column	

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OBJECTIVE	CONTENT	METHOD
	2) These vertebrae are not very strong. Back injuries can occur in health fields if the person does not use good body mechanics in lifting and moving. d. Flat bones 1) The bones in the rib cage 2) Protect soft tissues and vital organs within the body 3. Bones are made up of several types of cells a. They store vitamins and minerals b. Bones manufacture blood cells c. Broken bones are very painful 4. Joints -- areas which one bone connects with others a. Joints are necessary for movement b. Joints are made up of many structures c. Different joints have different movements 5. Muscles are what make all movements possible a. Groups of muscles work together to perform body motion b. Muscles contract and relax which allow movement c. Muscle strain is the overstretching of your muscles	
2.10.2 Discuss body mechanics as it applies to you, the aide.	B. Body mechanics 1. A practice of positioning and moving one's body in an aligned and uniform manner 2. Purpose of good body mechanics -- using muscle strength and ability in moving residents and/or objects 3. Good body mechanics makes the best use of strength and avoids fatigue 4. By using good body mechanics you can prevent injuries; e.g., back strain and/or torn muscles and ligaments	Text assignment Lecture/discussion

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	5. Good body mechanics on the part of the aide decreases the chance of injury resulting to residents when moving or lifting them	
2.10.3 Demonstrate rules of good body mechanics.	C. General rules of good body mechanics 1. Use as many large muscles or groups of large muscles as possible a. Use both hands rather than one hand to pick up a heavy object b. Use the large muscles in your legs when picking up a heavy object instead of smaller back muscles. Squat down, bending your knees. Keep your back straight and raise up, using your leg muscles, <u>never</u> bend over at the waist to lift heavy objects. 2. Stand and sit straight. Good posture is essential to good body mechanics. 3. When lifting, your feet should be approximately the width of your shoulders (at least 12 inches apart). This gives a broad base of support. 4. Be as close as possible to what you are lifting or moving. Don't reach and try to lift or move an object. 5. If possible, push, pull or roll rather than lift. 6. Use your arms to support the object. The muscles of the legs actually do the job of lifting <u>NOT</u> the muscles of your back. 7. When doing work, always work with the direction of your efforts not against them. Avoid twisting your body as much as possible. 8. If you think the object is too heavy to lift, then get help. Don't try to lift it alone.	Demonstration of principles of good body mechanics Role play

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	9. Always move residents that cannot assist you using two people. It is easier on the resident physically and prevents you from being injured. 10. Lift smoothly to avoid strain. Always count, "one, two, three" with the person you are working with. Work in unison. Do this also with the resident. 11. When changing the direction of your movement, a. Pivot b. Turn with short steps c. Turn your whole body	
2.10.4 Discuss general rules for lifting/moving residents.	D. General rules 1. Always tell resident what you will be doing--remember resident may have fear of falling 2. Encourage resident to do as much as possible. Be sure you do not interfere with resident's balance or ability to ambulate 3. Recognize resident capacity and get assistance if needed 4. Use gait/transfer belts when appropriate 5. Position catheter tubes or other tubing where cannot be pulled. Do not raise catheter bag above insertion 6. Give most support to heaviest part of resident's body 7. Hold resident close for most support 8. Do NOT move/support by resident's arms, underarms or shoulders. Use gait belt 9. Move slowly allowing resident to maintain/ regain control at each step, sitting, standing, etc.	Discussion

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	10. Have resident sit on side of bed a short time before standing--reduces faintness--allows circulation to readjust. 11. Be gentle--do not pull/push or tug unnecessarily 12. Move/turn resident toward you - keep side rail up on opposite side 13. Moving resident with one-sided weakness a. Have resident move toward stronger side b. When helping ambulate, stand on weaker/affected side of resident 1) Doesn't interfere with resident's balance 14. Falling resident a. Support as resident falls b. Stay with resident until adequate help arrives	
2.10.5 Demonstrate the ability to lift and move a resident in bed.	E. Lifting and moving a resident in bed 1. Resident's position in bed should be 2-4" from top of mattress 2. Ask for help from another staff member when resident cannot assist 3. Wash your hands 4. Ensure resident's privacy/explain what you will be doing 5. Lock wheels on bed 6. Remove pillow - place at head of bed 7. Stand on opposite sides of the bed (when you have help) 8. Stand straight, turned toward head of the bed slightly. Your feet should be at least 12 inches apart. Bend your knees. Keep your back straight. 9. Put one arm under the resident's shoulder nearest you	Trainex: "Lifting and Moving Patients" "Transfer Activities and Ambulation" Skills Checklist #7

Overview: **This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.**

OBJECTIVE	CONTENT	METHOD
	10. Put your other arm under the resident's buttocks	
	11. The other aide will do the same (if you have help)	
	12. You will then slide the resident's body up in bed. Straighten your knees as you slide the resident. Work as a team, count, "1, 2, 3, move"	
	13. Move resident gently to prevent pain or discomfort	
	14. If draw sheet on bed, untuck each side grasp in 2 places slide sheet with resident toward head of bed	
	15. Reposition the resident comfortably	
	16. Wash your hands	
	17. Report any unusual observations to immediate supervisor	
	F. Appropriate use of gait transfer belt	Skills checklist #8
	1. Explain procedure	
	2. Position resident for application	
	3. Apply tight enough to prevent riding up - loose enough for you to grasp	
	4. Stand in front of resident - support weak foot with inside of foot	
	5. Lean forward - grasp both sides of belt	
	6. Guide toward destination with gait belt support	
2.10.6 Demonstrate the ability to transfer a resident from bed to chair.	G. Transferring a resident from bed to chair	
	1. Check interdisciplinary plan to see if physical therapy has prescribed best way to transfer	
	2. Discuss activity with resident--tell resident you will be helping him/her to get up in the chair	Skills Checklist #9
	3. Wash your hands	
	4. Ensure privacy	

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OBJECTIVE	CONTENT	METHOD
	5. Lock wheels on the bed 6. Position chair appropriately to facilitate moving the resident toward the unaffected/ strong side 7. Place bed in the low position 8. Assist resident toward the edge of the bed 9. Raise the back rest so resident is in a sitting position 10. Lower side rails 11. Assist resident so that he/she is sitting on the side of the bed. Feet should be dangling over the side of the bed. Assist with robe/shoes - if appropriate apply transfer/gait belt 12. Allow time for resident to adjust to change in position. Prevents faint feeling 13. Stand facing resident. Put your hands under transfer belt at waist. Assist him/her to stand at the bedside 14. Pivot turn and assist resident in turn 15. Position resident comfortably/fasten safety straps if needed. Be sure there is good body alignment. 16. Place call bell where resident can reach it 17. Wash your hands 18. Check resident frequently while he/she is up in the chair, base frequency on resident's condition/or care plan orders	
2.10.7 Describe general use of stretchers.	H. Definition and purposes of a stretcher 1. A stretcher (sometimes called a litter or gurney) is a wheeled cart on which residents remain lying down while they are moved from one place to another 2. Stretchers are used to transport a resident that: a. Can not sit in a wheelchair	

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	b. Can not tolerate being transferred in a sitting position due to illness c. Is unconscious	
	3. Always have help when moving a resident from bed to the stretcher	Lecture/discussion
	4. When pushing a stretcher a. Always have the side rails elevated and the safety straps fastened before moving the resident b. Stand at the resident's head c. Push the stretcher so the resident is moving feet first	Role play Example of stretcher
	5. When entering an elevator, turn the stretcher so that you enter head first. Stand at the resident's head when the elevator is in motion	
	6. When leaving an elevator, push the stretcher out foot end first	
	7. When going down a ramp, guide the vehicle from the foot end. Always glance behind you to see if your way is clear, to prevent any collisions	
	8. Never leave a resident unattended on a stretcher	
	9. Always lock the stretcher wheels when you are not moving it	
	10. Cover the resident with a blanket or sheet when he/she is on the stretcher, provide them with a head pillow	
2.10.8 Describe the procedure to move a resident from the bed to a stretcher.	I. Moving a resident from bed to stretcher 1. Assemble your equipment a. Stretcher b. Sheet to cover stretcher c. Sheet or blanket to cover the resident, pillows for comfort	Equipment needed: Stretcher Sheets 2-3 persons

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	2. Two or three people to assist in the transfer/moving resident 3. Discuss with resident that you will be moving him/her to a stretcher. Explain why and how 4. Insure privacy 5. Raise the bed so that it is even with the stretcher 6. Lock the wheels of the bed 7. Cover resident with a top sheet 8. Place stretcher next to the bed 9. Lock the wheels of the stretcher/bed 10. You will stand on the far side to the bed, your body will hold the bed in place 11. Your partner(s) will stand on the far side of the stretcher using their body to hold the stretcher in place 12. You should both (all) have your knees bent, your backs straight, and your weight balanced on both feet 13. At the signal "one, two, three," push, pull and slide the resident from the bed to the stretcher. Use a lift sheet whenever possible 14. Support the resident's head and feet with pillows 15. Cover resident with blanket 16. Fasten safety straps at hips and shoulders 17. Put side rails up on stretcher 18. Wash your hands 19. Move resident foot end first to destination	
2.11 Recognize the necessity of helping resident maintain normal body alignment.	XII. Body alignment A. Normal body alignment (good body posture) 1. Maintains correct functioning and optimal comfort for the resident 2. When the body is well aligned, undue strain is not placed upon the joints, muscles and body tissue	Text assignment Lecture/discussion

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	3. Correct body alignment is achieved when muscles are in a position of slight flexion and relaxed state 4. If confined to bed, body alignment needs to be correct and comfortable to prevent contractures, pressure sores and pain 5. Correct positioning of the resident's body is referred to as body alignment. The proper support and alignment of the resident's body is one of the aide's tasks 6. An ill or confined resident must have his/her position changed at intervals of every 2 hours or more often as indicated by specific care orders for the resident. 7. When a person's body is in correct body alignment: a. Head is erect, not flexed forward nor extended backwards b. Vertebral column is in normal alignment c. The extremities are positioned according to the position of the resident. d. Feet are in the "walking" position. e. The wrists are neither flexed nor extended. Fingers are slightly flexed. f. Hips are straight in line with the thighs.	Lecture/discussion. Trainex: "Positioning to Prevent Complications"
2.11.1 Discuss the causes of postural changes in the elderly that affects positioning.	B. Posture of elderly residents 1. Postural variations in the elderly are caused by: a. Arthritis b. Muscle atrophy c. Osteoporosis d. Contractures f. Response to severe pain 2. Usually the typical posture of an elderly person is one of flexion a. Head and neck are flexed slightly forward	

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	b. Eyes look down c. Spinal column is flexed forward d. Slight flexion exists at the hips and knees 3. The speed at which older people walk is slowed due to this flexed posture a. Small shuffling steps are taken b. Balance is not good due to the reduced strength of the hip, knee or back muscles c. Pain at the joints of the hips, knees, or anrus and disc of spine	
2.11.2 Describe how the care plan should be utilized in determining the positioning of the resident.	C. Care plan as guide for positioning resident 1. A bedridden resident requires a position change every 2 hours to: a. Maintain comfort b. Prevent flexion contractures c. Prevent skin pressure/breakdown 2. Positioning resident a. Resident's condition b. Special exam/procedure c. Prevention of further complications 3. Importance of positioning as part of overall care	Discussion - care plan Positioning Requirements
2.11.3 Demonstrate correct positioning of a resident in the supine position.	D. Correct positioning of a resident in the supine position 1. In the supine position, the resident is lying on his/her back with face upward 2. Head is in a straight line with the spine 3. Toes point upward 4. Usually arms are bent at the elbows and the hands are resting at the sides of the resident's body or one arm may be over resident's head to relax the back and shoulder muscles 5. A pillow may be placed under resident's head	Skills Checklist #10

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OBJECTIVE	CONTENT	METHOD
	6. Pillows may be used to elevate heels and prevent legs from rotating outward 7. Caution - be sure materials used for positioning do not restrict circulation E. Correct positioning of a resident in a side lying position 1. Resident is lying on his/her side 2. Head is in line with his/her spine 3. Body is in straight alignment 4. One pillow should be under the resident's head 5. Place a pillow near the resident's chest for arm to rest on 6. Check lower arm - pull shoulder/arm forward/hand out from beneath side 7. A third pillow is folded in half lengthwise and tucked against the resident's back. This will keep resident on his/her side. 8. A fourth pillow should be placed between the resident's legs so that he/she can rest one leg on it instead of the other leg	
2.12 Identify causes of disabilities due to immobility.	XIII. Problems with immobility A. Contracture 1. Shortening/thickening of ligaments and tendons 2. Causes limited movement B. Causes of contractures 1. Occurs when range of motion has not been done frequently enough/or to full degree consistently (daily) 2. When no precautions, e.g., handrolls are used, and the rules of correct positioning/support of paralyzed body parts is maintained 3. If a contracture exists, any forced movement must be especially avoided, because pain and injury can easily occur	

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	4. Contractures occur very quickly in stroke victims and amputees. Studies show that within three days changes in muscle tissue from disuse occurs	
	C. Foot Drop/Wrist Drop 1. Occurs in residents who is not ambulatory 2. When not used, muscles in foot allow foot to fall down 3. Positioning prevents a. Block or board used - hand rolls b. Maintain foot at right angle to legs (walking position) c. High top shoes d. Foot splints e. Pillows placed at bottom of bed - push foot to neutral position	
2.12.1 Discuss the role of the aide in prevention of contractures or foot drop.	D. Methods for prevention of foot drop or contractures 1. Range of motion exercises 2. Handrolls, sand bags, foot boards	Lecture/discussion
2.12.2 Assist the resident to safely ambulate.	E. Ambulation 1. Activity/exercise a. Circulation b. Muscle strengthened/endurance c. Prevent system compromise/complication d. Independence - autonomy/sense of of well being 2. Determine resident functioning level a. Balance b. Strength c. Endurance d. Psychological health e. Physiological health 3. Check care plan to determine if there are special procedures (PT, RN) regarding method to transfer	Skills Checklist #11

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	4. Principles a. Good body mechanics b. Know resident's ability/activity endurance c. Discuss activity/purpose with resident d. Encourage resident 5. Equipment a. Walkers, cane, crutches b. Gait/transfer belt c. Prosthesis/orthotics d. Wheelchair 6. Process to assist with ambulation a. Determine functioning level - get help if needed b. Explain to resident what you will be doing c. Assist to sitting position - allow to maintain balance d. Support in dressing or putting on gown and appropriate shoes e. Place gait belt around waist - be sure properly positioned (see previous) f. Stand facing resident with hands under gait belt g. Assist to stand--support with gait belt h. If resident has a weak side, aide should check care plan to see if there is recommendation regarding where aide should give support 1) If recommendations - follow 2) If no recommendations - stand and give support on resident's affected (weaker) side i. To ambulate, stand at side or slightly behind - stand on affected (weaker) side if no other orders	

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	j. Walk slowly--observe for tiredness, weakness k. If resident becomes faint, starts to fall; gently lower to floor, get help l. Report - record	
2.13 Demonstrate the ability to perform range of motion. 2.13.1 Define range of motion. 2.13.2 Define the types of ROM.	XIV. Range of motion A. ROM - the extent to which a joint is capable of being moved 1. Active 2. Active assistive 3. Passive	Lecture/discussion
2.13.3 Discuss guidelines for ROM.	B. Guidelines 1. Know why you are doing ROM 2. Make resident aware of what you are going to do or want them to do 3. Establish rapport; put resident at ease 4. Use good body mechanics 5. Provide proper joint support 6. Be aware of individual safety needs 7. Perform motions smoothly, slowly, and rhythmically 8. Do not force 9. Do each motion 10 times 10. Have resident wear clothing that does not restrict movement and allows you to observe motion 11. Report any change in mobility or deformity noted	Lecture
2.13.4 Identify the major bones and bony landmarks in the body.	C. Bones 1. Skull 2. Mandible 3. Spine - cervical, thoracic, lumbar sacrum, coccyx 4. Ribs 5. Sternum 6. Scapula	Lecture Palpatation Skeleton/chart

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	7. Clavicle 8. Humerus 9. Ulna 10. Radius 11. Carpal bones 12. Metacarpals 13. Phalanges 14. Pelvis 15. Femur 16. Patella 17. Tibia 18. Fibula 19. Tarsal bones 20. Metatarsals D. Bony landmarks 1. Great trochanter 2. Malleolus a. Medial b. Lateral 3. Iliac crest 4. Humeral head	
2.13.5 Identify major extremity joints and demonstrate the motion available at each joint.	E. Upper extremity 1. Shoulder a. Flexion/extension b. Abduction/adduction c. Internal rotation/external rotation d. Horizontal abduction/adduction 2. Elbow - flexion/extension 3. Wrist a. Flexion/extension b. Radial deviation c. Ulnar deviation d. Pronation - movement occurs at supination - elbow and wrist 4. MCP (metacarpal phalangeal) a. Flexion/extension	Lecture/discussion Demonstration Lab Skills checklist #12

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Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
	b. Abduction/adduction 5. PIP (proximal interphalangeal) flexion/extension 6. DIP (distal interphalangeal) flexion/extension 7. Thumb a. MCP/DIP - flexion/extension b. CMC (Carpalmetacarpal) 1) flexion/extension 2) abduction/adduction 3) opposition 8. Lower extremity a. Hip 1) flexion/extension 2) abduction/adduction 3) internal/external rotation b. Knee - flexion/extension c. Ankle - dorsiflexion 1) plantar flexion 2) inversion 3) eversion d. MTP (metatarsal phalangeal) 1) flexion/extension 2) adbuction/adduction e. PIP - flexion/extension f. DIP - flexion/extension	
2.13.6 Discuss factors influencing muscle control.	F. Muscle control 1. Contracture 2. Spasticity 3. Flaccidity 4. Clonus 5. Rigidity	Lecture
2.13.7 Discuss the effects of limited ROM on function.	G. Discuss functional limitations that would occur if a particular motion were limited at any joint	Lecture/discussion

Overview: This unit explores the resident's environment and describes the nurse aide's responsibility in maintaining a safe environment for the resident. Skills include medical asepsis, organizing resident's unit, recognizing and correcting safety hazards, and transporting and positioning resident.

OBJECTIVE	CONTENT	METHOD
2.13.8 Demonstrate active and passive ROM.	H. Procedure for range of motion 1. Active ROM is when the resident can exercise his/her own joints. Important they do this to prevent atrophy, and maintain functioning capacity 2. Passive ROM is when the nursing staff and/or physical therapist exercises the resident's joints for them 3. People who have suffered a stroke and have subsequent paralysis of certain extremities have passive ROM performed on a regular basis 4. Active and passive ROM can be done on the same resident. Always encourage the resident to do the exercises on their own, if possible 5. Encourage them to do ROM when in the bathtub if they are able. The water is relaxing to the muscles. G. Summary of aide's role 1. Be sure that resident is in correct body alignment at all times 2. Make use of all equipment that your facility provides; e.g., handrolls in a supply closet will not prevent a resident from getting a contracture, but a handroll properly placed in a resident's hand will 3. Encourage the resident to move joints while bathing and/or you move the extremities for them 4. Encourage the resident to tighten and relax all their muscles frequently throughout the day	Skills checklist #12

6/92 kjb
1/93 kjb
7/93 kjb

Unit III PERSONAL CARE OF RESIDENT

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

Teaching Time: 8-10 hours

OBJECTIVE	CONTENT	METHOD
3.0 Describe personal hygiene needs of residents and identify nurse aide's role in helping resident meet these requirements.	I. Personal hygiene requirements of a resident	Text assignment
3.1 List the daily hygiene requirements of all people.	A. Daily hygiene practices 1. Personal hygiene is the daily care that people do for themselves when able 2. When incapable of performing activities help is needed--but encourage to do as to do as much as possible 3. Basic hygienic needs a. Elimination b. Personal cleanliness c. Oral hygiene/mouth care d. Grooming e. Skin care g. Clean clothing	Lecture/discussion
3.2 Describe some of the factors that affect a person's hygiene practices.	B. Factors that affect a person's hygiene practices 1. Cultural 2. Social 3. Familial 4. Individual preferences 5. Illness 6. Behavioral limitations 7. Physical/mental limitations 8. Financial limitations	
3.2.1 List special considerations for helping nursing facility residents meet daily care needs.	C. Special considerations 1. Allow resident to follow established pattern a. The personal preference of the resident is important. Not every individual brushes their teeth before bathing or after all meals	Lecture/discussion

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
	1) Individual differences should always be considered by the health care team b. Residents with poor hygiene habits require explanations and teaching of importance of good hygiene and personal cleanliness	
3.3 Assist resident with oral hygiene.	D. Oral hygiene 1. Cleaning the person's mouth and teeth 2. Essential part of daily hygienic needs a. An ill person's mouth and teeth need even more care than a person who is well physically b. People feel better if their mouth is clean and fresh c. Teeth should be brushed every morning and evening and after each meal d. A person's mouth and teeth can cause health problems if they are not kept clean e. When a person is ill, various problems are noted/occur within/around oral cavity 1) Bad taste/odor 2) Tongue may feel "fuzzy" 3) Lack of saliva--secretion to keep their mouth moist. Lips and gums may become cracked and sore. This can lead to infection 4) Medications prescribed for specific illness can lead to infections, bleeding, or dryness of oral mucosa f. Oral hygiene should be given to residents with special needs, oxygen therapy and/or fluid restrictions every two hours to keep mouth moist and prevent complications 1) Semi-conscious	Text assignment Lecture/discussion

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
	2) Unconscious 3) Mouth breathers 4) NPO g. Use a soft bristled toothbrush - brush in circular motions h. Use activity to stimulate gum circulation as well as clean teeth i. If assisting with care, wear gloves	
3.3.1 Demonstrate the ability to assist with oral hygiene for a conscious resident.	E. Giving oral hygiene to a conscious resident 1. Assemble your equipment - check to be sure labelled with resident's name 2. Wash your hands--wear gloves at all times 3. Insure privacy 4. Tell resident you will assisting him/her with oral hygiene 5. Spread towel across the resident's chest to protect gown and/or sheets if resident is to remain in bed 6. If resident can walk to the bathroom or to sink in the room, have them do so 7. Mix water and mouthwash in equal proportions 8. Have resident rinse his/her mouth with the solution 9. The resident should then expectorate the solution 10. Resident is to, if possible, put toothpaste on a wet toothbrush 11. Have resident brush his/her teeth - appropriately - circular motion on all surfaces 12. Assist them in rinsing their mouth, if necessary 13. Clean/dry equipment and put it away 14. Report any unusual conditions to supervisory nurse	Skills Checklist #13

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
	F. Principles for assisting in care of dentures 1. Prevent from breakage - lined basin - water 2. May soak in cleaning (tablet) solution before brushing 3. Store in denture cup in bedside when not in use (dry or wet) 4. Report dentures that do not fit properly - affect eating, appearance, etc.	
3.3.2 Demonstrate the ability to assist with oral hygiene for a resident that wears dentures.	G. Cleaning dentures/partial plates "false teeth" 1. Assemble equipment 2. Wash your hands 3. Insure privacy 4. Tell resident you wish to help with cleaning his/her dentures/teeth 5. Ask resident to remove dentures and place in emesis basin that is lined with a paper towel. If unable, the aide must remove (gloves should be worn if suspected infection/bleeding) i.e., respiratory/cold or mouth sores 6. Take the dentures to the sink 7. Be very careful with the dentures to prevent breaking 8. Fill denture cup with cool water and mouthwash/soaking tablet or use a prepared solution 9. Line sink with paper towels or fill with water to prevent breakage 10. Apply toothpaste or denture cleanser with dentures in the palm of your hand. Brush until they are clean 11. Rinse thoroughly under cool running water 12. Have resident rinse his/her mouth with mouthwash	Contained in Skills Checklist #13

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
	13. Replace dentures in mouth. Be sure dentures are moist (makes easier to put in mouth) 14. Clean/dry equipment and put away 15. Wash your hands 16. Report any unusual conditions to supervisory nurse	
3.3.3 Determine when a resident would need to have oral hygiene done for them.	H. Determine need for assistance 1. Due to illness 2. Physical deformities 3. Paralysis 4. Comatose resident 5. Mental/physical limitations	Lecture/discussion
3.4 Assist resident with bathing.	II. Bathing a resident	Text assignment
3.4.1 Identify four purposes of bathing.	A. Reasons for bathing 1. Cleanse the skin 2. Eliminate odors 3. Refresh a person 4. Stimulation of circulation and prevent pressure sores	Trainex: "Bed Bath"
	B. Four ways of bathing a resident 1. Complete bed bath 2. Partial bath (face, hands, perineal care) 3. The tub or whirlpool bath 4. The shower	Lecture/discussion
3.4.2 List the rules to follow when giving a bed bath to a resident.	C. Rules to follow 1. Assemble all of your equipment before you begin 2. Offer resident opportunity to use bathroom/bedpan before starting the procedure 3. Keep resident covered to prevent chilling 4. Use good body mechanics 5. Make a mitten of wash cloth. Prevents dragging the edges across the resident's skin.	Text assignment Lecture/discussion/demonstration

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
	6. Water should be 105°-115° - always change after perineal care 7. Wash and dry only one part of the body at a time 8. Soap can dry the skin--be sure to rinse 9. Putting the resident's feet and hands into the water is very relaxing 10. Examine the resident's skin while bathing. Report any discolored skin, redness, blisters, rashes, broken skin or tender places or pressure areas you see. 11. Never trim or cut toenails without a special order from your supervisor 12. Warm any lotion in the palm of your hand/or place closed bottle in warm bath water before applying it to the resident's skin 13. Check linen and gowns for personal belongings before putting them in the laundry	
3.4.3 Determine when a partial bed bath should be given.	D. Partial bed bath 1. Between tub baths/whirlpool/showers 2. As A.M. or P.M. care 3. Can be given at sink or in bed 4. Assist resident with washing face, hands, back and perineum 5. Procedure similar to complete bath	Lecture/discussion
3.4.4 Demonstrate a partial bath.	E. Partial bath - general information 1. Assemble all of your equipment before you begin 2. Provide privacy throughout procedure 3. Keep resident covered to prevent chilling 4. Use good body mechanics 5. Make a mitten of wash cloth. Prevents dragging the edges across the resident's skin	Text assignment Lecture/discussion/ demonstration Skills checklist #14

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
	6. Water should be 105°-115° - always change after perineal care if continuing to wash other body parts	
	7. Wash and dry only one part of the body at a time	
	8. Soap can dry the skin--be sure to rinse	
	9. Offer bedpan or urinal before you begin	
	F. Procedure for partial bath	
	1. Arrange equipment conveniently in close reach/check room temperature, adjust if resident requests	
	2. Wash hands	Skills checklist #14
	3. Provide privacy and explain to resident what you will be doing	
	4. Offer bedpan and/or urinal	
	5. Raise bed to high position	
	6. Place bath blanket over top linen	
	7. Fanfold top linen to foot of bed without exposing resident	
	8. Position resident comfortably, flat if resident can tolerate	
	9. Remove resident's gown and jewelry	
	10. Place soiled gown in linen bag and jewelry in bedside stand	
	11. Fill wash basin two-thirds full with water 105°-115°F (36.1°C). Use a bath thermometer to check temperature, if available	
	12. Assist resident to move to side of bed near aide	
	13. Place towel across resident's chest	
	14. Make a mitten with the wash cloth	
	15. Wash resident's face	
	16. Dry resident's face, using patting motion	
	17. Place towel under the resident's far arm	
	18. Wash, rinse and dry hand and axilla	

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
	19. Repeat procedure with other hand and axilla area 20. Wash and pat dry areas where there are body folds and creases (under breast, abdominal folds) 21. Put on gloves 22. Place towel or protective covering under buttocks 23. Position bath blanket without exposing resident 24. Perform perineal care 25. Men - Cleanse penis by pushing back fore-skin, gently washing, penis, scrotum, and anus 26. Women - Gently separate labia - wash down one side then the other (front to back) 27. Rinse and dry thoroughly. Turn resident on side 28. Using warm soap and water, wash, rinse, dry rectal area (wash from perineum toward rectum) 29. Empty, rinse and clean equipment 30. Remove gloves 31. Assist resident to dress in clean, dry clothes. Position comfortably or assist out of bed. 32. Place linen over resident. 33. Make resident comfortable. 34. Wash hands 35. Report any unusual observation	
3.4.5 Demonstrate a complete bed bath.	G. Bed Bath 1. Assemble equipment 2. Wash your hands 3. Insure privacy 4. Tell resident what you will be doing	Skills Checklist #15

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
	5. Offer bedpan or urinal before you begin 6. Arrange equipment conveniently in close reach/check room temperature, adjust if resident requests 7. Cover resident with a bath blanket and then remove top linen 8. Position resident comfortably 9. Remove jewelry 10. Remove soiled gown (provide privacy) 11. Fill wash basin two-thirds full with water 105°F to 115°F (36.1°C). Use a bath thermometer to check temperature, if available. 12. Use good body mechanics 13. Wash resident's face first. Rinse and dry by patting gently. 14. Place towel under resident's far arm to protect the bed, then wash shoulders, axilla and arm. Rinse and dry well. Repeat procedure with near arm. 15. Put resident's hand in the water and wash with soap. Clean resident's fingernails. 16. Wash other arm and hand in the same way 17. Place towel across resident's chest. Fold bath blanket down. Wash their neck and chest. Examine the skin under female resident's breasts. Dry thoroughly. 18. Expose to pubic area and wash abdomen. Dry well. 19. Empty water and refill basin 20. Place towel under one of the resident's legs. Wash and dry well. 21. Place far foot in basin and wash. Dry all creases and between the toes well. Repeat procedure with near leg. 22. Turn resident on his/her side	

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
	23. Wash, rinse and dry his/her back, buttocks and back of neck	
	24. Apply lotion and complete a back rub.	
	25. Offer resident a soapy cloth and ask him/her to wash their genitals. If they are not able to do this, then you will wash the perineum	Trainex: "Peri Care"
	26. Assist the resident in dressing in clean clothes and gown	
	27. Clean equipment and put it away	
	28. Position resident comfortably	
	29. Report any observations to supervisor	
3.4.6 Demonstrate the procedure for providing perineal care.	H. Perineal care	See procedure book for your facility
	1. Perineal area	
	2. Principles of care	Text assignment
	a. Done during bath, after voiding, defecating, when incontinent or before catheter care	
	b. Cleanses - prevents complications	
	3. Procedure	Skills Checklist #16
	a. Wash hands - use C.D.C. precautions, use gloves	
	b. Provide privacy and explain procedure to resident	
	c. Remove soiled pads, clothing - dispose of bag appropriately	
	d. Men - Cleanse penis by pushing back foreskin, gently washing, penis, scrotum, and anus	
	e. Women - Gently separate labia - wash down one side then the other (front to back)	
	f. Wash buttocks and upper thighs	
	g. Rinse/dry thoroughly	
	h. Dress in clean, dry clothes, position comfortably or assist out of bed	

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
	i. Clean and return equipment j. Wash hands k. Report any unusual observations	
3.4.7 Identify nurse aide's responsibility in assisting with a whirlpool.	I. Whirlpool bath 1. In a whirlpool a resident is submerged to chest level in a comfortable chair height sitting position 2. The resident is placed in a chair lift and lowered into the whirlpool 3. Whirlpool action <u>helps</u> with cleaning resident. However all body areas need washed. 4. Needs assistance to wash hair and shoulders 5. Whirlpools help prevent bed sores and can help heal existing bed sores 6. Procedure to assist: a) The whirlpool should be filled with water before resident is lowered in water b) Provide privacy c) Always check the temperature of the water before lowering a resident in the whirlpool (105-115° F.) d) Check equipment for proper functioning e) Be sure resident is safely fastened in the chair lift before raising it f) Have resident keep elbows inside of the chair to avoid pinching while being lowered into the whirlpool. Watch to make sure feet are clear of lifting chair. g) Reassure resident as needed h) Never leave resident unattended in a whirlpool (or any other bath tub or shower) i) Only use the special soap that is for whirlpool baths. Use proper amount	Lecture/discussion Skills Checklist #17

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
	j) Be very careful with washcloths as they can get lost and plug the drain k) Disinfect whirlpool and chair according to facility standards	
3.4.8 Demonstrate the ability to assist a resident with a tub bath and/or shower.	J. Tub baths 1. Assemble equipment 2. Wash your hands 3. Discuss with resident that you will be assisting him/her with bath 4. Insure privacy 5. Assist resident out of bed. Assist him/her in putting on bathrobe and slippers. Assist to the tub room either by walking or by wheelchair 6. Check for possible safety hazards in bathroom 7. Clean tub with disinfectant solution 8. Fill the tub one-half full of water at 105°-115°F. (40.5°C.). Test the temperature with a thermometer. 9. Place a towel in the bathtub for the resident to sit on 10. Place a towel/nonslip pad on the floor where the resident will step out of the tub. This will prevent slipping. 11. Assist resident to get undressed and into bath tub 12. Assist resident to wash self, if needed. Be sure good perineal care has been completed. 13. Put a towel on the chair 14. Assist resident out of the tub, being very careful that he/she doesn't slip. Assist the resident into a chair 15. Dry resident well. Assist the resident to dress. 16. Return resident to room or wherever the resident is to go at that time	Text assignment Trainex: "Shower and Tub Baths" Skills Checklist #18

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
	17. Clean bath tub and area. Remove all soiled linen. 18. Wash your hands 19. Report any unusual findings	
3.4.9 Assist a resident with a shower.	K. Assisting a resident with a shower 1. Remember that showers can be slippery 2. Procedure is the same as tub bath 3. Use a shower chair. NO standing. 4. Check the temperature of water before allowing resident in the shower 5. Always keep soap in soap dish. A bar of soap can cause accidents to self and/or resident could slip on soapy floor 6. Assist with perineal care as needed	
3.4.10 Discuss purpose, procedure and demonstrate the therapeutic back rub.	L. Therapeutics of back rub 1. Rubbing a resident's back is refreshing and relaxing 2. Relaxes muscles 3. Stimulates circulation 4. Usually given during daily hygiene - after the resident's bath, in the evening before bedtime, and as indicated for preventive and supportive treatments 5. Preventive/supportive measures a. Every time you change a residents position especially the critically ill and bedridden resident, or individual with physical and mental limitations b. Provide a relaxation and comforting therapeutic response c. Aids circulation around any existing or pre-stage ulcers	Text assignment Lecture/discussion
3.4.11 Demonstrate the ability to perform a back rub.	M. Methods of back rubs 1. Explain to resident what you are going to do, and why	

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
	2. Provide privacy - cover with sheet or bath blanket	
	3. Position resident on side/or abdomen	Skills checklist #19
	4. Warm lotion by holding under warm water or by warming it in your palms	
	5. Rub scapula, coccyx and shoulders with circular motion	
	6. Continue to rub for 1 1/2 - 3 minutes	
	7. Remove towel, place in dirty linen	
	8. Reposition resident	
	9. Wash hands	
	10. Report to charge nurse any areas of continued redness after back rubs, or any open areas, rashes or blisters noted	
3.5 Assist resident with grooming.	III. Providing other hygiene tasks	Demonstration/return
3.5.1 Demonstrate the care of a resident's hair including shampooing.	A. Shampooing a resident's hair	Lecture/discussion
	1. Grooming frequently associated with a person's sense of well being/feeling healthy	Skills Checklist #20
	2. The frequency is usually once a week/ or more depending on any scalp condition or resident preference	
	3. Most residents have their own favorite brand of shampoo	
	4. A creme rinse can prevent tangling	
	5. Beauty shops may be available for shampoos, hair cuts, styling or perms	
	6. When you assist a resident with a shampoo, be sure that all of the shampoo is rinsed out of their hair to prevent drying and itching of the scalp	
	7. Protect eyes and ears of resident when shampooing	
	8. Clean brush and comb on shampoo days	
	B. Combing a resident's hair	Lecture/discussion
	1. Hair should be combed daily after morning care and whenever necessary throughout	

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
	the day - use resident's own brush	
	2. Clean comb and brush before starting	Role play
	3. Brushing and combing stimulates blood circulation and brings oils to the surface and spreads them evenly over the hair	Checklist with Grooming #22
	4. Residents feel better about themselves if their hair is combed and styled attractively	
	5. If you comb the resident's hair in bed, always cover the pillow with a towel	
	6. Gently brush up from the neck toward the top of the head. This stimulates the scalp.	
	7. While combing, hold a small section of hair between the scalp and the comb to prevent pulling	
	8. If hair is long, start at the ends and work towards the scalp	
	9. Long hair should be braided to prevent tangling, but try to style it the way the resident likes it, if possible	
	10. Resident should always be encouraged to comb their own hair if physically possible	
	11. This can be a very important part of resident's personal care	
	12. Observe scalp for any signs of disease or any cuts/tender lumps noted	
	13. Record hair shampooing in resident's record, and if any findings of cuts/abrasions, scalp or hair disease are reported to charge nurse	
3.5.2 Assist residents with nail care.	C. Care of nails	Demonstration
	1. Reasons	
	a. Harbor bacteria - cause infection	Skills Checklist #21
	b. Resident scratch self and/or staff	
	2. Condition	
	a. Living habits, diet affects condition	

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
	b. Disease 3. Precautions - DO NOT trim nails on these residents a. Poor circulation 1) Diseases of circulatory system (peripheral vascular disease) 2) Diabetes b. More susceptible to infections/other problems 1) Nail disease 2) Suppressed Immune System 4. Fingernail procedure a. Soak fingertips in warm, soapy water 2-3 minutes b. Push cuticle back c. Use file to clean under nails d. Trim and smooth nails e. Report to nurse in charge any cuts/sores/ rashes or blisters on a resident hands/ around/under nails f Report nail care to supervisory nurse. Record if required g. Clean equipment to be reused and store 5. Foot care a. Soak in warm soapy water b. Cut straight across toenail (rounding causes in-grown toenails) c. Massage feet with lotion d. Sweet oil or foot cream softens calluses e. NEVER trim corns, calluses or blisters f. Report any cuts/blisters, rashes or sores found on the feet or around nails g. Record foot care in resident's record, if required h. Clean equipment to be reused and store.	

ONAL CARE OF RESIDENT

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
3.5.3 Discuss the general principles of dressing and undressing a resident.	D. Dressing and undressing a resident 1. A person in a long term care facility should be dressed in their "street" clothes (including underclothing) whenever possible 2. Be sure clothing is appropriate for time/season and resident's preference and comfort 3. The resident should dress themselves whenever possible 4. If resident needs assistance: a. Remove night clothes before dressing b. Remove one arm of a shirt or blouse at a time. Residents with physical limitations from strokes or arthritis may have difficulty bending/reaching with arms or legs - they will require more assistance and slower pace. c. Sometimes raising both arms over the head and putting on or removing the sleeves on both arms at once prevents stretching of the shoulder muscles and pain, especially with people that have arthritis. d. If the resident is paralyzed on one side, dress the affected arm or leg first and remove the clothing from that arm or leg last e. NEVER jerk or pull clothing off. Always be gentle and remove clothing slowly. f. Do NOT put resident's clothes on backwards. Use adaptive clothing when necessary, i.e., velcro closures/snaps g. Dressing aids/tools resident can use 1) Long shoe horn 2) Reaching tongs/grabbers 3) Reacher	Text assignment Lecture/discussion Skill Demonstration Skills Checklist #22 Role play

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
	4) Velcro straps 5) Dressing hooks - hooks, zipper	
3.5.4 Discuss the importance of assisting the resident with a shave.	E. Shaving a resident's facial hair 1. Residents with unwanted facial hair should be shaved daily/as needed or by resident preference 2. If able, provide equipment; let resident shave self 3. If ill or weak, you will shave the resident 4. Always check with your supervisor before shaving a resident that you have not shaved before 5. Be sure face is washed/dried before shaving 6. Be sure resident has dentures in when shaving 7. Use either the resident's razor or facility's to shave resident 8. Shaving can be done with an electric razor. Electric razors are never used if a resident is receiving oxygen, unless it can be turned off for the time it takes to shave him/her 9. When using an electric razor, always move the razor in appropriate direction (circular--round blades) 10. Check facility policy regarding use of safety razors 11. Safety razors should not be used on residents with a. Bleeding disorders b. Medication - blood thinners c. Confusion d. Uncooperative 12. Report any unusual findings	Lecture/discussion Skills Checklist #23

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
3.6 Discuss methods of assisting residents with elimination needs. 3.6.1 Discuss the purposes for using bedpans or urinals. 3.6.2 Demonstrate the ability to assist a resident with a urinal.	IV. Residents elimination needs A. Giving a male resident a urinal. 1. Assemble equipment 2. Wash your hands 3. Ask visitors to leave room and insure privacy/pull curtain or close door 4. Assist resident to stand if able--usually easier for male to void standing 5. Give urinal to the resident or place for resident when needed/gloves may be worn if resident has urinary tract infection, or other contagious contact infections 6. Place the signal cord within easy reach. Ask resident to signal you when he is finished. 7. Wash your hands. Leave the room to give the resident privacy, if resident's condition permits 8. After a short time, or when the resident signals, return to the room 9. Cover the urinal and take it to the resident's bathroom 10. Note characteristics of urine - normal is clear golden to straw colored. Abnormal is amber, tea or blood colored, cloudy or has sediment, or foul smell. Save a specimen to show charge nurse if findings look abnormal 11. Measure the urine if the resident is on intake and output. Record amount on I/O form 12. Empty the urinal into the toilet. Rinse the urinal with cold water. Do not contaminate faucet with urinal 13. Put the clean urinal back in the resident's bedside stand 14. Assist resident to wash his hands	Text assignment Skills Checklist #24

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
	15. Wash your hands, record information on resident record	
3.6.3 Demonstrate the ability to assist a resident with a bedpan/fracture pan.	B. Giving a resident a bedpan 1. Assemble your equipment 2. Wash your hands 3. Ask visitors to leave the room and insure the resident's privacy/pull curtain or close door 4. Fold back top sheets so they are out of the way when placing them on bedpan. Provide privacy 5. Ask the resident to: bend his/her knees; put feet flat on the mattress; raise hips by pressing feet on the mattress. If necessary, help the resident raise buttocks by slipping your hand under the lower part of back. Place the bedpan in position under the buttocks. 6. Sometimes the resident is unable to lift buttocks to get on or off the bedpan. In this case, put opposite side rail up, turn resident on side with resident's back to you. Turn the resident back onto the bedpan 7. Use overhead trapeze for those residents able to lift with upper extremities, or get assistance of another co-worker to prevent strain to resident and/or self. Replace the covers over the resident 8. Raise the back and knee rest if allowed, so the resident is in a sitting position. 9. Put toilet tissue and the signal cord where the resident can reach them easily 10. Ask the resident to signal when finished 11. Raise the side rails to the up position	Skills Checklist #25

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
	12. Wash your hands. Leave the room to give the resident privacy. 13. After a short time, or when the resident signals, return to the room. Help the resident to raise hips so you can remove the bedpan or have them turn while holding bedpan secure 14. Gloves should be worn in cases where resident has obvious bleeding or your hands have open sores 15. Help the resident if unable to clean themself. Turn the resident on side, clean anal area with toilet tissue from front to back 16. Take bedpan to the resident's bathroom 17. If specimen is required, collect it at this time. Measure the urine if the resident is on intake and output 18. Check the feces or urine for abnormal appearance/characteristics. Report to charge nurse a. Blood b. Diarrhea c. Odorous stools/urine d. Pus 19. Empty the bedpan 20. Follow your institution's policy for cleaning the bedpan 21. Put the bedpan back in resident's room in the bedside stand 22. Help resident wash their hands 23. Lower back and knee rests 24. Make the resident comfortable 25. Wash your hands 26. Reposition the signal cord and leave room/ record stool in resident's record 27. Report anything unusual to supervisory nurse	

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
3.6.4 Discuss the purpose of a bedside commode.	C. Bedside commode 1. Description 2. Used when a resident can go to the bathroom, but walking to the bathroom is not possible 3. Commodes are more comfortable than bedpans/ and promotes bowel evacuation 4. The resident uses the commode like a toilet 5. Always lock the wheels when positioning the commode, prior to resident sitting down 6. Never leave a resident alone on a commode if there is any possibility of them falling/ or if they are ill or weak 7. Give resident call light and instruct them to signal when they are finished 8. Assist resident off commode, assist with hygiene and return to bed or chair 9. May wear gloves to empty commode/and clean as needed. Return commode to storage place 10. Record stools/and any abnormalities as reported to charge nurse	Example of commode Lecture/discussion
3.7 Discuss methods to prevent pressure sore. 3.7.1 Describe pressure sores, and critical factors related to their formation.	V. Pressure sores A. Area where the skin is broken because of direct-continual pressure (see Unit II Objective 2.6.4) 1. Places on the body that receive continual pressure - making them prone to developing sores in a part of the body a. Shoulder blades b. Elbows c. Knees d. Heels e. Ankles f. Backbone - coccyx	Text assignment Trainex: "The Prevention and Treatment of Decubiti"

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
	g. Ears h. Back of head i. Between fingers and toes	
3.7.2 List five causes of pressure sores.	B. Causes 1. Interference by reduction or absence of circulating blood to a part/parts of the body 2. Bony prominence are the most susceptible to pressure sores 3. Areas to observe include sacrum, heels, elbows, spine or back of head 4. The pressure is a result of a continual - direct contact of the body or body parts 5. Residents confined to beds, chairs or carts, who do not move without assistance are high risk for pressure sores 6. Residents who require leg braces, splints, and other restrictive orthotics are susceptible to sores forming due to friction/pressure placed on skin 7. Residents who are non-communicative/ unresponsive need to have all bony areas checked with each repositioning	
3.7.3 Identify the conditions that can lead to the formation of or worsening of a pressure sore.	C. Conditions that affect the formation of pressure sores 1. Continued pressure 2. Heat, moisture and lack of cleanliness 3. Irritating substances on the skin, such as perspiration, urine, feces, material from wound discharges or soap that has been left on the skin 4. Malnutrition - dehydration 5. Immobility - friction - shearing 6. Foreign objects, e.g., crumbs, buttons or caring utensils	Lecture/discussion

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
	7. Wrinkles/soiled sheets 8. Improperly fitted/too tight of braces, clothing, socks or shoes can lead to pressure sores.	
3.7.4 Describe the signs and symptoms of a pressure sore.	D. Signs and symptoms of pressure sores 1. Initial symptoms - report to nurse immediately a. Reddened - bluish discoloration b. Warm - hot c. Tenderness d. Painful e. A sensation of burning/pressure 2. Advanced stages a. Blister may form b. Skin may have a break c. Color may darken 3. Physical and mentally limited residents are more prone to develop pressure sores/and skin break down because: a. Their skin is very fragile/tears easily b. They may not have an adequate amount of tissue padding over their bones/loss of muscle and fat stores c. They need to be reminded to turn and change positions d. Dependent on others for mobility e. Behavior imbalances 4. Obese people tend to get pressure sores on areas where their body parts rub together. a. Places to check for formation of pressure sores are the folds of the body where skin touches skin 1) Under the breasts 2) Between the folds of the buttocks 3) Between the thighs 4) Abdominal folds	Lecture/discussion

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
3.7.5 Discuss the aide's role in prevention of a pressure sore.	E. Prevention of pressure sores 1. Everyone's responsibility 2. Result of carelessness or a lack of knowledge and skill in caring for residents 3. Once formed, hard to heal 4. Report the first sign of a pressure sore to nurse 5. Turn the resident often. Change their position at least every two hours. 6. Don't leave a resident on a bedpan, toilet or commode, longer than 15 min. without rechecking on their needs 7. Keep resident's skin clean and dry 8. If an area is becoming reddened, massage area with lotion frequently throughout your shift. If skin is broken, massage around area. Report to supervisory nurse 9. Use powder in skin folds of obese people, a light dusting, wipe out any excess to prevent caking or clumping of powder 10. Linen should be clean, dry and as wrinkle free as possible 11. If resident is incontinent, check frequently for urine or feces. Clean resident up immediately and wash with soap and water. Dry skin thoroughly. 12. Massage the bony prominences each time you turn a resident with lotion using a gentle circular motion to increase the circulation 13. Move carefully - prevent shearing	Lecture/discussion
3.7.6 Identify and discuss the various special equipment you may use in the prevention of pressure sores.	F. Equipment useful in the prevention of pressure sores - does not replace good nursing care 1. Air cushions 2. Sponge rubber cushions/foam cushions	Examples of special equipment used by your facility

Overview: This unit explores the personal hygiene needs of the resident and the nurse aide's role in helping residents meet these needs. Oral hygiene care, bathing, grooming, and elimination needs are included.

OBJECTIVE	CONTENT	METHOD
	3. Cotton rings for heels and elbows 4. Pillows 5. Alternating air mattress 6. Water beds 7. Flotation pads 8. Sheep Skin 9. Commercial pressure relieving devices/ beds, wheelchair cushions or pillows 10. Foam mattress pads (egg crate type) 11. Protective dressing materials (i.e., DuoDerm)	

6/92 kjb
1/93 kjb
7/93 kjb

Unit IV Nutrition

Overview: In this unit the student explores the normal basic body structure and function related to the aspect of nutrition, the nutrients required in a well balanced diet, diet modifications required to treat special conditions and assisting resident to fulfill nutritional needs.

Teaching Time: 3 hours

OBJECTIVE	CONTENT	METHOD
4.0 Briefly identify the basic body structure of the digestive system and the functions that occur during digestion of food.	I. Body nutritional needs A. The digestive system 1. Converts food to energy 2. Action a. Chemical b. Mechanical	Text assignment Lecture/discussion
	B. Parts of digestive system 1. Mouth a. Teeth b. Tongue c. Salivary glands 2. Esophagus 3. Stomach 4. Small intestines 5. Large intestines 6. Liver, pancreas, gallbladder	Diagrams: The digestive system the mouth the digestive system internal view Lecture/discussion
	C. Digestion 1. Total process from intake to excretion takes 36 hours 2. Absorbed from small intestine	
4.1 Discuss eight digestive changes that may occur in residents that affect nutrition.	D. Special digestive considerations for residents 1. Food may be digested more slowly 2. There may be a need for fewer calories 3. Constipation is more common 4. Decreased appetite/decreased thirst 5. Lose ability to distinguish certain smells, or not as easy to recognize smell 6. Gag/swallowing reflex weakened 7. Decreased saliva secretions/hard to swallow 8. Poor dentition/loose dentures impede chewing process	

Overview: In this unit the student explores the normal basic body structure and function related to the aspect of nutrition, the nutrients required in a well balanced diet, diet modifications required to treat special conditions and assisting resident to fulfill nutritional needs.

OBJECTIVE	CONTENT	METHOD
	9. Prone to diarrhea from fatty-rich foods 10. Medications affecting taste of foods, sensitivity to foods, or stomach upset	
4.2 List components of a well-balanced diet.	E. Well balanced diet 1. Dietary variety and balance at each meal using four basic food groups 2. Supplementary diet management to achieve adequate vitamins, minerals, and electrolytes in a 24 hour period	Text assignment
4.2.1 Discuss the food guide pyramid.	F. Food guide pyramid 1. Definition - 4 tiers a. Outline of what to eat daily b. Contains a variety of foods--that contain required nutrients c. Focuses on fat to encourage decreasing intake 2. Components a. Bread, cereal, rice, and pasta 1) 6-11 servings 2) More sugar/less fat b. Fruit and vegetable group 1) 2-4 servings fruit 2) 3-5 vegetable group c. Milk, yogurt, cheese and meat, poultry, fish, beans and nuts 1) 2-3 servings milk group 2) 2-3 servings meat group d. Fat and sweets - use sparingly	Handout "Pyramid" Discussion
4.3 Identify fluid needs of residents.	3. Water/fluid needs a. Helps keep body tissues in balance - very essential to health 1) Determines amount of water and chemicals in blood 2) Blood content determines amount of water in body tissues	

Overview: In this unit the student explores the normal basic body structure and function related to the aspect of nutrition, the nutrients required in a well balanced diet, diet modifications required to treat special conditions and assisting resident to fulfill nutritional needs.

OBJECTIVE	CONTENT	METHOD
	3) Helps maintain body temperature, blood pressure, blood/tissue chemistry b. Average adult needs 3-4 pints of water a day (6-8 glasses) c. If adult looses 1/5 body fluid, death results d. Encourage fluid intake e. Passing drinking water 1) Passed at regular intervals 2) Use resident's preference regarding ice 3) Follow infection control procedures--be sure residents get own water pitcher back	
	G. Guidelines to follow in passing drinking water 1. Wash hands 2. Check resident's preference regarding ice/water temperature 3. Names should be on water containers 4. Do not touch rims or inside of glasses with hands 5. If ice given, be sure scoop handle is kept out of ice 6. Ice container should be transported in covered container 7. Be sure each resident gets their own pitchers back 8. Be aware of resident fluid restrictions or special considerations when passing waters 9. Record fluid and/or nutritional intakes as ordered	Handout "Excerpts from Food Service Manual"

Overview: In this unit the student explores the normal basic body structure and function related to the aspect of nutrition, the nutrients required in a well balanced diet, diet modifications required to treat special conditions and assisting resident to fulfill nutritional needs.

OBJECTIVE	CONTENT	METHOD
4.4 Describe selected basic therapeutic diets that you will see in a nursing care facility.	H. Therapeutic diet 1. Modifications of a normal diet for purposes of correcting/creating a dietary condition or disease process 2. Ordered by a physician for a. Diabetes b. Heart disease/hypertension c. Allergy to certain foods d. Obesity e. Peptic ulcer disease f. Kidney/renal g. Immunosuppresive disease h. Medications interact	Lecture/discussion
	I. Common therapeutic diets 1. Low sodium diet 2. Weight reduction diet 3. Bland diet 4. Diabetic diet 5. Mechanically altered a. Soft b. Pureed c. Edentulous 6. Low cholesterol 7. Low fat 8. Renal 9. NAO inhibitor diet	Examples of sample diets
4.5 Identify your role as an aide in preparing the ambulatory resident for meals.	II. Aide's role in helping resident meet dietary needs	Text assignment
	A. Preparing resident for meals 1. All residents should be toileted, clean and dressed for meals 2. All residents who are physically able should be eating in the dining room unless specified otherwise in care plan	Lecture/discussion

Overview: In this unit the student explores the normal basic body structure and function related to the aspect of nutrition, the nutrients required in a well balanced diet, diet modifications required to treat special conditions and assisting resident to fulfill nutritional needs.

OBJECTIVE	CONTENT	METHOD
	3. Cheerful, attractive environment, food should appear appetizing 4. Mealtime is a social time 5. Your attitude should be cheerful and helpful at meal times. Residents eat more slowly and require more time for meals 6. Dietary habits and preferences should be maintained when possible, and if not contraindicated by resident's condition 7. If residents don't eat a. Find out the reason b. Must offer substitutes c. Check diet and be sure substitutes okay 8. Dietary changes affect the resident's level of independence, help the resident accept/deal with these changes	Role play Part of Checklist #26 - Preparing for meals Feeding the resident
4.6 Assist the confined resident with meal preparation.	B. Preparing confined residents for meals 1. Meal time can be a happy time for bed residents 2. Show the resident what he/she will be eating 3. Provide time for resident to use bathroom and wash hands before serving tray 4. If he/she is able, they might be more comfortable sitting up in a chair. If not, the head of the bed should be elevated 5. Clear away any unpleasant objects, e.g., bedpan, urinal or soiled linens 6. Make sure resident is comfortable and can reach his/her tray comfortably 7. Check to see they have proper diet 8. Make sure food such as meat is cut in small pieces and within reach and containers opened	Lecture/discussion

Overview: In this unit the student explores the normal basic body structure and function related to the aspect of nutrition, the nutrients required in a well balanced diet, diet modifications required to treat special conditions and assisting resident to fulfill nutritional needs.

OBJECTIVE	CONTENT	METHOD
	9. If possible, sit with resident while they begin their meal to determine possible problems and to encourage a social environment 10. After resident has eaten meal, note a. What was eaten b. Fluids taken (for intake) and record c. Resident's comments concerning meal likes and dislikes d. Provide with wet hand cloth to wash hands e. Offer bedpan/urinal - or assist to bathroom for elimination functions 11. Assist resident to chair or repositioning in bed after elimination need 12. Report any pertinent information to charge nurse C. Adaptive devices 1. Plate guards 2. DICEM pad 3. Adaptive utensils 4. Special cups/glasses 5. Divided plates D. Use verbal encouragement to assist the resident 1. Be pleasant/social and comment on how good the food looks, etc. 2. Remind residents to eat--specific foods, etc. 3. If feeding, remind to swallow 4. Encourage - with verbal directions	Display for students to see
4.7 Identify your role as an aide in feeding a resident.	E. Nurse aide's role 1. Adults usually find that being fed makes them feel resentful, depressed or helpless 2. When feeding a person, make sure your attitude is helpful and pleasant 3. Before feeding, properly position resident 4. Encourage the resident to do as much as possible for themselves	Text assignment Lecture/discussion

Overview: In this unit the student explores the normal basic body structure and function related to the aspect of nutrition, the nutrients required in a well balanced diet, diet modifications required to treat special conditions and assisting resident to fulfill nutritional needs.

OBJECTIVE	CONTENT	METHOD
	a. Have resident hold utensil/glass b. Guide/steady resident's hand 5. Do not rush residents through their meals. Most residents need more time. 6. Give resident time to chew the food thoroughly and swallow 7. Check the temperature (drop on arm) of hot liquids before feeding them to resident, the sensitivity to heat may be decreased 8. Syringes to feed residents should be used only as last resort a. Aides may do it only after being instructed by supervisory nurse b. Approved to do it by supervisory nurse 9. Foods that are to be eaten hot should be eaten first 10. If resident can not see foods well enough to distinguish what they are eating, tell them what you will be feeding them: "This is mashed potatoes, now try some carrots". This type of communication helps the resident in feeling comfortable while being fed 11. No sipping or blowing - no touching the food 12. Food that is not eaten is returned to dietary department	Role play: Choose partners. Blindfold one of the students. Have the other person feed the blind-folded student. Reverse roles.
4.8 Demonstrate the ability to feed a resident.	F. Feeding a resident in bed 1. Tell resident you will be assisting him/her with meal 2. Position the resident comfortably. Head of bed elevated as much as possible/allowed	Return demonstration Skills Checklist #26

Overview: In this unit the student explores the normal basic body structure and function related to the aspect of nutrition, the nutrients required in a well balanced diet, diet modifications required to treat special conditions and assisting resident to fulfill nutritional needs.

OBJECTIVE	CONTENT	METHOD
	3. Make yourself comfortable. If you sit down in a chair you and the resident will be more relaxed 4. Tuck a napkin under resident's chin 5. Season food according to resident's preference and diet 6. Fill spoon only half-full (use the tip of the spoon, not the side) 7. Put the food in the side of the resident's mouth 8. Talk with resident as you are feeding - encourage to swallow - tell them what you are feeding them 9. Alternate liquids and solids 10. Use a straw, unless contraindicated, for liquids 11. Feed resident slowly 12. Record fluid intake 13. Wipe resident's mouth 14. Clean area 15. Position resident comfortably 16. Note: a. How much was eaten b. Substitutes made c. Any comments concerning meal 17. Report to immediate supervisor	
4.9 Assisting/feeding the resident with problems swallowing.	III. Residents who have problems swallowing (dysphagia) A. Causes 1. Dentures not fitting 2. Decreased sensitivity 3. Decreased gag reflex B. Diet 1. Soft or pureed 2. Smaller, more frequent feedings	Lecture/discussion Handout

Overview: In this unit the student explores the normal basic body structure and function related to the aspect of nutrition, the nutrients required in a well balanced diet, diet modifications required to treat special conditions and assisting resident to fulfill nutritional needs.

OBJECTIVE	CONTENT	METHOD
	C. If soft or modified diet, be sure you tell resident what eating 1. Position body and head to facilitate swallowing 2. Use 1/2 teaspoon per bite. Place in mouth appropriately 3. Give liquids as prescribed 4. Encourage/remind residents to chew and swallow 5. Feed each food separately, helps better experience flavor 6. May need to check mouth for pocketing D. Coughing - small sips of water between bites E. Do not use syringe feeders 1. Amount given resident not controlled 2. Do not provide stimulus for swallowing	
4.10 Discuss the role of between meal nourishments.	IV. Between meal nourishment/nutrition supplement A. Between-meal nourishments/supplementation 1. Extra nourishments (snacks) are given to residents at specific times throughout the day - required at bedtime (h.s.) 2. The snack may be liquid or solid food 3. The main points to consider when passing out snacks are: a. Special diets b. NPO c. Fluid restrictions d. Food restrictions e. Reporting for supplement taken needs to be recorded for calorie monitoring B. Be sure resident gets nourishment that does not conflict with diet	Text assignment

NURSE AIDE COURSE

Unit V

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

Teaching time: 8-10 hours

OBJECTIVE	CONTENT	METHOD
5.0 Provide routine care procedures within nurse aide role.	I. Vital signs	Text assignment
	A. Measurement	
5.1 Discuss vital signs and define the abbreviations for each.	1. Temperature - measures the degree of heat of the body	Lecture/discussion
	a. Elderly/disabled more sensitive to hot and cold	
	b. Heat/cold mechanism not as sensitive	
	c. Higher temperatures	
	d. Susceptible to heat stroke	
	e. Sensitive to sun reactions	
	2. Pulse - the rate the heart beats	
	3. Respiration - the rate the person breathes in and out	
	4. Blood pressure - how much pressure/force the circulating blood creates against the arteries	
	B. Abbreviations for vital signs	
	1. Temperature - T	
	2. Pulse - P	
	3. Respiration - R	
	4. Blood pressure - BP	
	5. Vital signs - TPR and BP	
5.1.1 List methods of measuring body temperature.	C. Measuring vital signs - TPR	Text assignment
	1. Body temperature	Handout "Worksheet on Vital Signs
	a. Measurement of the degree of heat in the body	
	b. Created in the process of digesting and converting food into energy	
	c. Lost through	
	1) Perspiration	
	2) Respiration	
	3) Excretion	Lecture/discussion

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	D. Measurement of body temperature 1. Measure by a thermometer a. Either glass or electronic b. Calibrated in Celsius or Fahrenheit c. Oral, rectal, axillary, tempanic (ear)	Trainex: "Temperature, Pulse, and Respirations"
5.1.2 Identify the normal body temperature of adults. Differentiate fahrenheit and centigrade.	E. Normal Average Adult Temperature 1. Orally 98.6°F = 37°C 2. Rectally 99.6°F = 37.5°C 3. Axillary 97.6°F = 36.4°C 4. Measurement scales a. Fahrenheit = F° b. Centigrade = C° c. Orally = O° d. Rectally = R e. Axillary = Ax	
5.1.3 Discuss procedure to take an oral temperature. 5.1.4 Demonstrate the ability to accurately obtain an oral temperature.	5. Obtaining an oral temperature with mercury thermometer a. Check resident for factors that affect results/environmental and external 1) Smoking 2) Ice water 3) Hot drinks 4) Cool/hot room 5) Blankets 6) Clothing layers b. Physiological factors affect temperature 1) Body composition 2) Illness 3) Condition/Stress c. Inspect thermometer d. Wipe disinfectant off e. Shake thermometer down - apply thermometer cover f. Insert thermometer under tongue	Skills Checklist #27

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	g. Leave thermometer in 3-8 minutes for oral h. Stay with those residents designated by supervisor/care plans i. Remove cover j. Read thermometer correctly k. Record reading l. Disinfect per procedure/protocol 6. Obtaining an oral temperature with electronic thermometer a. Remove from battery b. Use probe - probe cover c. Insert under tongue d. Leave in place as indicated e. Read--discard probe f. Record g. Return to battery unit	
5.1.5 List resident conditions that require a rectal temperature.	F. Conditions requiring rectal temperature 1. Physician's order 2. Children < 5 years 3. Appliances on resident's face 4. Sneezing or coughing spells 5. Mouth is inflamed/infection 6. Receiving oxygen 7. Chronic twitch/tic 8. Oral surgery 9. Frequent seizures 10. Safety precautions for residents with special problems a. Delirious b. Unconscious c. Confused d. Restless e. Facial or nerve paralysis f. History of seizures	Text assignment Lecture/discussion

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	g. Uncooperative h. Mentally disabled i. Unable to understand/cooperate with oral mode	
5.1.6 Discuss the procedure for obtaining a rectal temperature. 5.1.7 Demonstrate the ability to obtain an accurate rectal temperature.	G. Obtaining a rectal temperature 1. Inspect thermometer/if electronic, secure probe cover 2. Insure resident's privacy 3. Position resident on side (you may need assistance) 4. Wipe off disinfectant 5. Put on rectal glove 6. Lubricate thermometer or probe cover 7. Insert thermometer - 1/2 to 1 inch - hold thermometer in place - always stay with the resident 8. Leave mercury thermometer for 3-5 minutes check electronic for signal 9. Read thermometer correctly 10. Record reading 11. Disinfect thermometer - replace in storage	Skills Checklist #27
5.1.8 Identify resident conditions when an axillary temperature should be taken.	H. Factors that determine need for axillary 1. Physical deformities 2. Rectal surgeries 3. Diarrhea and vomiting 4. Any factor that could influence the obtaining of a temperature by other means	Text assignment
5.1.9 Discuss the procedure to obtain an axillary temperature. 5.1.10 Demonstrate the ability to obtain an accurate axillary temperature.	I. Obtaining axillary temperature - use oral thermometer 1. Inspect thermometer 2. Insure resident's privacy 3. Shake thermometer day 4. Dry under arm, if sweating 5. Correctly position thermometer 6. Have resident place arm across chest	

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	7. Leave thermometer in place 7-12 minutes 8. Stay with resident during procedure 9. Read thermometer correctly 10. Record reading J. Tempanic (ear) temperature 1. Method - inservice 2. Normals	
5.1.11 Examine other methods of obtaining a temperature. 5.1.12 Accurately record temperature on temperature sheet.	K. Recording temperature 1. Right resident 2. Right date 3. Correct reading 4. Correct scale 5. Record routine if other than oral	Individual care facility's vital recording sheets
5.1.13 Determine when immediate supervisor should be notified concerning resident's temperature.	L. Immediate supervisor should be notified when 1. Temperature reading is above the previously stated normal ranges 2. Difficulties in obtaining temperature - uncooperative/resistant resident 3. Unusual observation, e.g., resident changes from previous condition. 4. Resident complaints of chills/fever	Text assignment Lecture/discussion
5.2 Discuss the normal structure and function of the circulatory system.	II. Circulatory System A. Circulatory system and vital signs 1. Blood - fluid circulating nutrition and oxygen 2. Heart - muscle which pumps blood 3. Blood vessels - circulate blood a. Veins b. Arteries c. Capillaries B. Function of blood 1. Carry oxygen and carbon dioxide 2. Carry nutrients to cells 3. Removes waste products 4. Carries hormones from glands	Handout of diagram or transparencies Trainex: "How the Heart and Circulatory System Works" "The Nervous System and the Cardiovascular System"

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	5. Maintains fluid/electrolyte balance 6. Defends the body against disease	
	C. Function of the heart 1. Pump for circulating blood a. Four chambers 1) Right atrium 2) Right ventricle 3) Left atrium 4) Left ventricle	Lecture/discussion
	D. Function of blood vessels 1. Dilate and contract to control body temperature 2. Transportation system for the blood 3. Arteries carry blood away from the heart 4. Veins carry blood back to the heart 5. Capillaries - one cell in thickness. Gas exchange and nutrient exchange take place	
5.2.1 Describe the circulatory system and the mechanism that causes a pulse.	E. Body mechanisms that "cause" the pulse/beat 1. Each heartbeat as it pumps blood 2. Expansion of arteries 3. Between heart beats and arteries contract and return to their normal size	Text assignment
	4. The heart pumps the blood in a steady rhythm 5. The rhythmic expansion and contraction of the arteries 6. The pulse measures the rate the heart is beating 7. Certain places on the body the pulse can be located with the finger tips	Trainex: "Temperature, Pulse and Respirations"
5.2.2 Identify the areas of the body where the pulse can be obtained.	a. Sites include 1) Brachial (B.p) 2) Carotid (CPR) 3) Radial (most common)	Role play

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
5.2.3 Identify the normal pulse rates. a. For a child. b. For an adult. c. For a geriatric resident.	F. Normal pulse rates - establish baseline 1. For a child a. 80 - 115 2. For an adult a. 72 - 100 3. For a geriatric resident a. 60 - 100; report if above or below these rates b. Effects of illness on the pulse 1) More variable 2) Faster - thready 3) Some medications slow pulse c. Cardiac conditions that affect the problem 1) Arrythmias (irregular heart beat) 2) Arteriosclerosis 3) Congestive heart disease 4) Hypertension d. Causes of increase or decrease in pulse rate/quality 1) Drugs 2) Caffeine 3) Fatigue 4) Stress 5) Emotional situations	Chart
5.2.4 Discuss the method of obtaining a radial pulse. 5.2.5 Define terms related to pulse.	G. Radial pulse 1. At radial artery on wrist 2. The thumb side of the hand 3. Easiest site to feel pulse 4. Rate - number of beats per minute 5. Rhythm - steady and regular 6. Force of beat - feeling of pulse against your fingers	

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
5.2.6 Demonstrate the procedure to obtain and record a radial pulse.	H. Obtain a radial pulse 1. Identify resident 2. Position resident comfortably 3. Position your fingers correctly 4. Count pulse for one full minute 5. Record pulse rate on TPR sheet a. Right resident b. Right date c. Correct count - within 3 beats d. Correct column 6. Notify immediate supervisor of abnormalities	Text assignment Skills Checklist #27 (TPR) Individual care facility's vital recording sheets
5.2.7 Describe the abnormal pulse beats that should be reported to your immediate supervisor.	I. Report the following immediately to your supervisor 1. Abnormal force a. Bounding pulse - 1) Occluded by mild pressure b. Feeble, weak and thready 1) Can be occluded by slight pressure 2) Usually a thready pulse has fast rate 2. Abnormal rate a. Bradycardia - pulse beat of under 60 for one full minute b. Tachycardia - pulse beat of over 100 for one full minute 3. Abnormal rhythm a. Irregularity of beats b. If it feels like beats are being "skipped" when being counted for one full minute c. Many geriatric residents have an abnormal radial rhythm due to changes that occur with age in their blood vessels	

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Includeo are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
5.3 Discuss the respiratory system, and the mechanisms involved in one's breathing.	III. Respiratory system A. Anatomy and physiology of respiratory system 1. Nose and mouth 2. Pharynx - throat 3. Trachea - windpipe 4. Larynx - voice box 5. Bronchi - branches into lungs 6. Lungs - organ which exchanges oxygen/ carbon dioxide	Text assignment Trainex: "Respiratory System, Digestive System and Special Senses"
	B. Nose and mouth function 1. Warm and filter air 2. Pharynx passage of air and food 3. Trachea carries air to lungs 4. Larynx is voice box 5. Bronchi carry air to lungs 6. Lungs allow the carbon dioxide to be expelled	Lecture/discussion Handout - Respiratory System
	C. Function of respiratory system 1. Supply body with air (oxygen) and release carbon dioxide 2. Interaction of circulatory system a. The heart pumps the blood through the arteries b. Blood circulates through the lungs c. Blood carries the oxygen to the different areas of the body d. Respirations - equals inhaling and exhaling	Text assignment Diagram of respiratory system
5.3.1 Identify the characteristics of respirations that should be reported immediately. 5.3.2 Identify and discuss the changes that can occur in respirations due to activity and medications.	D. Characteristics of respirations 1. Average rate of adults - 12-20 per minute 2. Causes of an increase and/or decrease in respiratory rate (below 12, above 28) a. Exercise b. Emotional stress c. Digestion of food	Chart of normal respiratory rates Lecture/discussion

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	d. Disease conditions/asthma e. Drugs f. Stimulants g. Heat h. Cold i. Age	
5.3.3 Demonstrate the procedure to obtain and record a respiration rate.	E. Obtaining a respiratory rate 1. Position resident on his/her back 2. Watch or feel resident's chest expand and contract as he/she breathes (count as 1 respiration) 3. Can be counted while taking radial pulse 4. Count natural respirations for one full minute 5. Recording respirations a. Right resident b. Right date c. Correct count - within 2 respirations d. Correct column	Skills Checklist #27 (TPR)
5.3.4 Determine when immediate supervisor should be notified concerning resident's respirations.	3. Immediate supervisor should be notified when respirations are: a. Labored - hard for resident to breathe b. Noisy - when resident breathes, you hear noise c. Slow - below 12 d. Fast - above 28 e. Irregular or shallow f. Report any other observations of anything unusual	Role play Lecture/discussion
5.4 Discuss the circulatory system in relation to blood pressure.	IV. Circulatory system A. Physiology of a blood pressure reading 1. Pressure in the arteries 2. Force of the blood pushing against the walls of the blood vessels	Text assignment Lecture/discussion

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	3. The amount of pressure in the arteries depends on two things: a. The rate of the heart beat b. How easily the blood flows through the blood vessels	Trainex: "Blood Pressure"
5.4.1 Name the two measurements that are obtained when measuring a blood pressure. a. Systolic. b. Diastolic.	4. Systolic pressure a. When heart contracts the blood pressure is the highest b. First sound you hear when measuring a blood pressure 5. Diastolic pressure a. The heart relaxes between each contraction b. The pressure goes down c. When heart is relaxed the pressure is the lowest d. When the sounds cease 6. When measuring blood pressure you are finding the systolic and diastolic measurements	Cassette Tape: Blood Pressure Sounds Lecture/discussion
5.4.2 Discuss the normal blood pressure in adults and the methods of assisting the resident to control blood pressure.	B. Causes of increase/decrease in blood pressure 1. Illness 2. Exercise 3. Emotional and physical stress 4. Diet 5. Medications 6. Stimulants/caffeine 7. Nutritional status 8. Diseases (Diabetic) C. Interventions/treatments to correct unstable blood pressure 1. Treatment of hypertension, prevention of strokes a. Regularly taking medication b. Controlled diet (low salt) c. Decrease in stressful situations	

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	d. Treatment of diseases or illnesses e. Monitor/record blood pressure at several spaced intervals daily 2. Treatment of hypotension a. Medication b. Change positions slowly c. Rise form lying or sitting position slowly	
5.4.3 Demonstrate the ability to correctly obtain a blood pressure.	D. Equipment for obtaining a B.p. 1. Stethoscope 2. Sphygmomanometer E. Procedure 1. Wash hands 2. Secure equipment 3. Position resident and explain procedure - palm upward, support at heart level 4. Wrap cuff securely around upper arm - 1 1/2 inch above brachial artery (bend of elbow) 5. Locate brachial artery/pulse at inside bend of elbow 6. Place stethoscope bell or diaphragm over artery 7. Pump sphygmomanometer up 170 mm or as indicated by palpation 8. Slowly let pressure out while listening 9. Note first sound (systolic) - must be within 4 mm 10. Note last sound (diastolic) - must be within 4 mm 11. Remove equipment - make resident comfortable 12. Record and report	Skills Checklist #28

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
5.4.4 Describe when your supervisor should be notified concerning a resident's blood pressure.	F. Supervisor should be notified immediately when a blood pressure is: 1. Above their normal range by 20 degrees systolic or diastolic 2. Below their normal range by 20 degrees systolic or diastolic 3. Any resident with systolic >200 or <100 diastolic >100 <50 4. Unable to palpate a brachial pulse 5. Or as indicated on care plan specific to resident's needs/levels	
5.5 Identify measures for accurately weighing the resident.	V. Weighing the resident A. Purpose for weighing 1. Baseline 2. Weight gain/weight loss can indicate health/health changes a. Fluid retention b. Fluid loss c. Nutritional status d. Medication adjustments/doses change e. Other disease (Diabetics) 3. Factors affecting weight accuracy a. Same time daily - early AM most accurate b. Resident's cooperativeness c. Resident's mobility level of strength/ agility B. Procedure for weighing 1. Familiar with scale used in facility 2. Using an upright scale a. Position resident correctly - facing scale b. Two bars c. Move until balanced d. Total numbers at each bar	Text assignment Demonstration Return demonstration

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	e. If resident has been weighed with shoes in the past, leave shoes on	
5.5.1 Demonstrate the ability to weigh a resident with an upright scale.	3. Procedure for upright a. Wash hands b. Take resident to scale c. Place weights to extreme left d. Help resident to remove shoes and step up on scale - position correctly e. Move weights to estimated weight f. Move weights until balanced bar hangs half-way between g. Add two figures and record h. Turn resident around. i. Lower height bar j. Calculate height k. Return resident to room l. Report weight variations of 2 lbs gain/ loss to immediate supervisor	Skills Checklist
5.5.2 Demonstrate the ability to weigh a nonambulatory resident.	4. Weight and height a. Wash hands - get assistance if needed b. Position resident correctly on scale c. Follow correct procedure for scale used d. Calculate or obtain correct weight reading e. Determine height by lowering bar f. Reposition resident g. Clean and return any equipment used h. Report/record 5. Weight/height measurements a. Pounds b. Feet/inches	

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
5.6 Discuss the role of the nurse aide to help resident maintain fluid intake.	VI. Fluid balance A. Fluid/electrolyte balance 1. Water is essential to life a. Intake of fluid through eating and drinking b. Output of fluid through urination, feces, vomitus or drainage 2. Fluid balance - equalized amounts of fluid consumed and excreted	Text assignment Lecture/discussion Trainex: "Intake and Output"
5.6.1 Discuss the role of the nurse aide in helping resident maintain fluid intake.	B. Fluid intake 1. The main source of fluids for the body is liquids taken orally (by mouth) a) Solid foods do contain some water b) Liquid foods are the major source of water 2. Fluid sources of water a) Oral fluids 1) Water 2) Milk (milk drinks) 3) Fruit juices 4) Soups 5) Coffee and tea 6) Ice cream (malts, etc.) 7) Jello 8) Pudding 9) Anything that is liquid at body temperature	Text assignment
5.6.2 Define the term fluid imbalance.	C. Fluid and electrolyte imbalance 1. An imbalance of fluids occurs when a) Too much fluid is retained in the body 1) Cells retain fluids causing swelling (edema in extremities) 2) When kidneys are unable to filter/ remove water from the body	Lecture/discussion

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	3) Related diseases affecting major organs upset electrolyte balance 4) Sodium and potassium levels are imbalanced causing fluid retention or excess excretion b) Excessive loss of fluids/electrolytes lead to dehydration during prolong episodes of: 1) Vomiting 2) Diarrhea 3) Bleeding 4) Excessive perspiration 2. Effects of illness on fluid and electrolyte balance a. Loss of appetite b. Decrease in fluids taken c. Muscle tissue shrinks and becomes dehydrated and more fibrous, causing diminished strength/health of muscle d. Depression, dementia and loneliness can decrease appetite and result in dehydration e. Debilitated and elderly may not recognize thirst f. Skin integrity - dryness and predisposes to skin breakdown	
5.6.3 Discuss the importance of accurately measuring and recording fluid intake and output.	D. Importance of measuring fluid intake and output 1. When resident loses more fluid than he/she is taking in or retains more than he/she is putting out a. Physicians can treat the causes of imbalances with: 1) Medications 2) Encouraging more fluids	Lecture/discussion

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	3) Restricting amount of fluid ingested 4) Diet modifications 5) Electrolyte supplements 2. The treatment of the physician depends on an accurate measurement of intake and output for a 24 hour period (daily) 3. Therapeutic interventions of fluid measurement: a. High blood pressure 1) Diet - low salt 2) Restrict fluids 3) Electrolyte supplements b. Kidney disease 1) Special diet 2) Restricted or encouraged fluids (depending on the type of kidney disease)	
5.6.4 Define abbreviations used for intake and output.	4. Abbreviations used for the terms Intake and Output a. Intake - abbreviated I. b. Output - abbreviated O.	
5.6.5 Identify the unit of measurement used in recording intake and output.	E. Cubic Centimeter (cc) 1. Unit of measurement used in recording I and O 2. Abbreviated cc 3. Metric system of measurement. 4. Example: 1 ounce = 30 cc 4 ounces = 120 cc 1 cup = 240 cc	Graph of conversion ounces to ccs Example of graduate
5.6.6 Discuss the procedure to measure fluid intake.	5. Measuring liquids in cubic centimeters (cc) a) Obtain a container that is used to measure liquids (called a graduate) b) Note the calibrations on the container c) Pour some liquid into the container d) Measure the amount of liquid in ccs and ounces	

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	e) Record the amount correctly on the I-O sheet	
5.6.7 Demonstrate the ability to accurately measure resident input.	6. Measuring intake a) Tell the resident that the amount of fluids he/she drinks is being recorded b) Ask the resident to help if he/she is physically able c) Observe all fluids resident drinks with meals and throughout your shift d) Record each measurement immediately on I-O sheet e) Be sure the resident has taken all of the fluid orally before recording the amount 1) If fluid is not totally consumed, record the amount that was taken orally f) Determine a total intake for your shift by adding all amounts - record	Role play Skills Checklist #30
5.6.8 Describe the aide's role in forcing fluids.	F. Force fluids means to encourage a greater oral intake of liquids 1. Sick and aged need encouragement to drink more 2. Residents may be required to drink more fluids due to disease or medication 3. Ways to encourage more fluids a. By showing interest and being positive b. Provide different kinds of liquids c. Offer liquids frequently d. Know resident's likes and dislikes e. Offer hot and cold liquids f. Often residents prefer frequent small sips, rather than full glasses of fluids g. Allow resident as much choice as possible in relation to types, amount, frequency	Text assignment Lecture/discussion Role play

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	of fluids 4. Forcing fluids a. Check assignment sheet and/or resident's Kardex b. Encourage resident to drink the required amount c. Use different kinds of fluids--noting resident's likes and dislikes and what is allowed on special diets, e.g., low sodium, diabetic diets, etc. d. Record the amount taken in orally on I-O sheet (in cc)	
5.6.9 Identify methods for assisting the resident who has fluids restricted.	G. Fluid restriction 1. Fluids are limited to certain amounts 2. Residents should have no more than the amount ordered 3. Restriction of fluids is common in: a. Cardiac disorders b. Renal disorders c. Brain tumors/trauma d. Liver disease 4. It's important to follow orders exactly and measure accurately 5. More frequent oral hygiene required 6. Explain to resident and family that he/she is to drink only what is given and no more 7. When a resident is on fluid restriction: a. Check assignment sheet and/or resident's Kardex b. Determine with immediate supervisor how many cc's resident can drink c. Measure amounts accurately, including dietary trays d. Encourage resident to drink all of allotted fluids	Text assignment Lecture/discussion Role play

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	e. Record the amount accurately on I-O sheets	
5.6.10 List methods for caring for resident who is NPO.	H. Nothing By Mouth (NPO) 1. Resident can not <u>eat</u> or <u>drink</u> anything at all 2. Many times oral hygiene is stopped also--Check with immediate supervisor 3. Residents may become irritable when they are not allowed to eat or drink 4. Nothing by mouth is a common order a. When preparing resident for diagnostic tests/surgical procedure b. When resident is experiencing nausea and vomiting c. When a resident is unable to swallow foods or fluids safely	Text assignment
	5. When resident is to be NPO a. Check assignment sheet and/or resident kardex b. Explain to resident that he/she will not be allowed to eat or drink c. Remove water pitcher and food from room d. Place a sign stating NPO on bed or door e. Do not give resident any fluids or food f. Make a note on I-O sheet that resident is NPO	Role play
5.6.11 Discuss the normal anatomy and physiology of the urinary system.	I. Output 1. Urinary system a. The kidneys b. The ureters (tubes leading from kidneys to bladder) c. The urinary bladder d. The urethra	Text assignment Lecture/discussion -

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	2. Purpose of the urinary system a. Rid the body of wastes through the process of urination b. Help maintain the fluid/electrolyte balance in the body 3. Chronically ill sometimes lose the ability of muscular contraction a. Resulting in urinary incontinence b. Which can lead to incomplete emptying of the bladder which results in cystitis	Trainex: "Anatomy and Physiology of the Kidneys, Ureters, and Bladder"
5.6.12 Discuss fluid output and the importance of measuring fluid output.	4. Fluid output a. Is the sum total of liquids that come out of the body 1) Urine 2) Diarrhea 3) Emesis 4) Perspiration/respiration 5) Drainage b. The most measurable fluid output is urine c. A resident who is on intake and output must have his/her output as well as his/her intake measured when using 1. Urinal 2. Bedpan 3. Emesis basin 4. Other drainage apparatus	Text assignment Lecture/discussion
5.6.13 List the steps to measure a resident's output. 5.6.14 Demonstrate the ability to accurately measure output.	5. Measuring fluid output a. Tell the resident that you will be measuring the amount of urine he/she is putting out b. Residents must use urinal and/or bedpan c. No toilet paper should be placed in container	Return demonstration Skills Checklist #30 continued (I&O)

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	d. Female resident should not allow their bowels to move while on bedpan e. Instruct male residents on use of urinals f. If stool or urine appears bloody, use gloves to do output g. Obtain a graduate (container) for measuring urine h. Pour urine from bedpan and/or urinal into graduate i. Place graduate on flat surface j. Measure the amount of urine and/or other fluids accurately k. Record amount on I-O sheet in ccs l. Rinse and disinfect graduate and urinal and return to resident's room	
5.6.15 Recognize when your immediate supervisor should be notified concerning resident's output.	6. Notify immediate supervisor if a. Unusual or abnormal output 1) Blood present in urine or feces 2) Diarrhea 3) Extremely hard stools or difficulty in defecation (bowel movement) 4) Pain upon urination or with defecation 5) Scanty, frequent urination 6) Cloudy, abnormal color of urine or odorous	Lecture/discussion
5.7 List common body specimens.	VII. Collecting specimen A. Specimen definition 1. The human body regularly gets rid of various waste materials 2. Most of the body's waste materials are discharged in the form of: a. Urine b. Feces c. Sputum	Text assignment Lecture/discussion

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	d. Perspiration/insensible body loss - respiration 3. Materials/specimens are obtained for laboratory analysis as indicated by the physician 4. Tests performed aid in diagnosing conditions/assessing resolution of an infection or condition.	
5.7.1 Identify the role of the nurse aide in obtain specimens.	B. Nurse aide's role in specimen collection 1. Follow procedure for the collection and labeling the specimen 2. Always wear gloves when obtaining/or handling specimens 3. Collect specimen at the correct time 4. Right person 5. Label the specimen correctly 6. Store specimen correctly a. Refrigerate b. Room temperature c. On ice d. However immediate supervisor instructs you 7. Use aseptic/clean technique in obtaining specimen 8. Always wash hands after completing procedure	Lecture/discussion
5.7.2 Label a specimen correctly.	C. Labeling a specimen 1. Print label clearly so that it is easily read 2. Information to include on label: a. Resident's name b. Room number c. Time and date specimen was collected d. What specimen is: Example 1) Sputum 2) Drainage from abdominal wound	

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	e. Miscellaneous info, Dr's name, resident's diagnosis or resident's temperature	
5.7.3 List the "ten rights" of specimen collection.	D. "Ten Rights" of specimen collection 1. The right resident 2. The right specimen 3. The right time 4. The right amount 5. The right container 6. The right label 7. The right requisition or laboratory (lab) slip 8. The right method 9. The right asepsis/technique 10. The right attitude	Lecture/discussion
5.7.4 Maintain asepsis in specimen collection.	E. Collecting specimens 1. Wash hands carefully to prevent spread of bacteria before and after obtaining specimen 2. Use correct utensils to assist in the aseptic collection of specimens a. Tongue blade for stool specimens b. Syringe for some urine specimens c. Gloves - CDC guidelines - always to be worn d. Immediate supervisor will instruct you on institution's individual policies	Discussion
5.7.5 List steps in the procedure for obtaining routine urine specimen.	F. Routine urine specimen 1. Single urine sample 2. Is taken routinely upon admission in hospital and in long term care facilities and when resident's physician orders one 3. No special technique needs to be done - can be done at any time	Text assignment Trainex: "Collecting Urine Specimens"

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	e. Miscellaneous info, Dr's name, resident's diagnosis or resident's temperature	
5.7.3 List the "ten rights" of specimen collection.	D. "Ten Rights" of specimen collection 1. The right resident 2. The right specimen 3. The right time 4. The right amount 5. The right container 6. The right label 7. The right requisition or laboratory (lab) slip 8. The right method 9. The right asepsis/technique 10. The right attitude	Lecture/discussion
5.7.4 Maintain asepsis in specimen collection.	E. Collecting specimens 1. Wash hands carefully to prevent spread of bacteria before and after obtaining specimen 2. Use correct utensils to assist in the aseptic collection of specimens a. Tongue blade for stool specimens b. Syringe for some urine specimens c. Gloves - CDC guidelines - always to be worn d. Immediate supervisor will instruct you on institution's individual policies	Discussion
5.7.5 List steps in the procedure for obtaining routine urine specimen.	F. Routine urine specimen 1. Single urine sample 2. Is taken routinely upon admission in hospital and in long term care facilities and when resident's physician orders one 3. No special technique needs to be done - can be done at any time	Text assignment Trainex: "Collecting Urine Specimens"

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	4. Results may reveal the following abnormalities: a. Blood in urine - hematuria b. Pus in urine - pyuria c. Specific gravity d. Cells present e. Amount of minerals present f. Glucose - Glycosuria g. Ketones - Ketonuia h. Electrolyte levels	
5.7.6 Demonstrate the ability to correctly obtain a routine urine specimen.	G. Obtaining routine urine sample 1. Assemble equipment 2. Wash hands/apply gloves 3. Identify resident 4. Insure privacy 5. Explain to resident a. What you will be doing b. Why you will be doing it c. How you will be doing it 6. Tell resident not to put toilet tissue in bedpan 7. Have resident urinate into clean bedpan or urinal 8. Prepare label correctly 9. Pour urine into graduate, measure and record amount on I-O sheet, if ordered 10. Pour urine into specimen container 11. Clean and rinse equipment 12. Store specimen correctly or send to laboratory 13. Report to supervisor that routine urine specimen was obtained 14. Report any unusual observations	Practice Return demonstration Skills Checklist #31

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
5.7.7 Discuss the term midstream clean-catch urine specimen.	H. Midstream Clean-Catch Urine Specimen (abbreviated CCUA).	Text assignment
	1. Free of contamination/organisms	Lecture/discussion
	2. Used to determine if bacteria is present in the urine	
	3. Strict asepsis must be maintained if urine specimen is to be free of contamination	
	4. This method of obtaining the urine requires that:	
	a. The urinary opening is thoroughly cleansed with a special towelette/non-sterile gloves must be worn	
	1) the urinary opening is called the meatus	
	b. The resident then begins to urinate a small amount. This urine is discarded.	
	c. The midstream is then obtained for the specimen directly into the sterile container	
	d. The resident then finishes urinating in the urinal or bedpan.	
	5. Remember you do not want to collect the urine when resident first voids or the last of the voiding. Only the middle (midstream) voiding is collected for the specimen.	
	6. This can be an embarrassing procedure for the resident. Maintain privacy and explain to resident completely what you are going to do	
	7. Obtaining a midstream clean-catch urine specimen	Discussion of procedure
	a. Assemble equipment needed	
	b. Wash your hands	
	c. Insure privacy	
	d. Explain procedure to resident/in simple terms (what, why, how)	

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	e. Follow the correct procedure for obtaining the urine 1) From a female resident 2) From a male resident 3) Non-sterile gloves should always be worn f. Maintain asepsis of urine container g. Label urine specimen correctly h. Send urine immediately to laboratory or store properly i. Wash your hands j. Report to immediate supervisor k. Report any unusual observations 8. Assist resident when obtaining urine as many people can not clean themselves adequately and may find the position uncomfortable a. Always wear gloves, non-sterile are appropriate b. Always explain to resident what you are doing 9. Insure the resident's privacy. Many residents are very modest concerning their genitals - be slow and gentle	
5.8 Briefly discuss the normal anatomy of the gastrointestinal tract.	VIII. Gastrointestinal system A. Group of organs that can carry out/ facilitate the digestive process 1. Gastro - stomach 2. Intestinal - bowel B. Components of intestines 1. Small intestines a. Duodeum b. Illeum 2. Large intestine (colon) a. Ascending colon	Lecture/discussion

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	b. Transverse colon c. Descending colon d. Rectum e. Anus C. Activity/function 1. Small intestine a. Carries end products of digestion for availability to the body b. Passes on end products from body metabolism to large intestine 2. Large intestine a. Receives body waste products b. Formation/transport of feces c. Excretion of feces via rectum to anus	
5.8.1 Recognize why the chronically ill and geriatric population are prone to gastrointestinal irregularities.	D. Causes 1. Fecal impactions/constipation a. Constipation b. Immobility c. Medications d. Inadequate fluid intake e. Inadequate/inappropriate dietary/habits f. Related diseases/conditions g. Inactivity/bedridden h. Unable/incomplete emptying of bowels i. Lack privacy/or unable to position self for better bowel elimination j. Loss of bowel control/muscular tone/ peristalsis	Lecture/discussion
5.8.2 Discuss other factors associated with chronic gastrointestinal irregularities.	2. Causes of chronic gastrointestinal irregularities a. Environmental - lack knowledge on normal bowel function b. Psychological - mental illness c. Physiological - segment of bowel missing	

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
5.8.3 Describe the symptoms and complications associated with fecal impaction.	E. Fecal impaction is a collection of hard feces/stool in lower portion of the bowel 1. Symptoms of impaction are a. Seepage of liquid fecal material around impaction reaches anus b. Constant feeling of a need to have a bowel movement c. Complaint of rectal pain d. Complaint lower abdominal pain/cramping e. Feeling of abdominal fullness/distension f. Feeling of nausea, loss of appetite and malaise 2. Constipation left untreated leads to fecal impaction 3. Fecal impactions prevent the normal passage of stool which can lead to an intestinal obstruction	
5.8.4 Discuss the symptoms and complications associated with constipation.	F. Constipation - condition of irregular or difficult bowel movements 1. Symptoms of constipation a. Abdominal fullness/distension b. Two-three days between bowel movements c. Headache, nausea, loss of appetite, general malaise d. Small/hard stools 2. Constipation can cause hemorrhoids due to difficult evacuation of bowel 3. Constipation left untreated leads to fecal impaction. 4. Compromises the individual's level of well-being and health. G. Care of bowel regularity/impactions 1. Purpose can be diagnostic or therapeutic a. Clean out the lower bowel b. Evacuation of impacted stool	

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	c. Promote bowel regularity 2. Requires an order from a supervisor or physician	
5.8.5 Discuss the nurse aide's role in bowel regularity and impactions.	3. Nurse aide's role a. Assist charge nurse with set-up and administration of enema or suppository b. Does not administer enema/suppository c. Supports resident by positioning and comforting resident during and after procedure d. Assist resident with bedpan/commode/or to bathroom to evacuate bowels e. Observe results/reports to supervisor and record results	
5.8.6 Discuss and identify the nurse aide's role in prevention and treatment of gastrointestinal irregularity.	H. Prevention of bowel irregularities 1. Therapeutic/supportive methods a. Observe resident's bowel movement and habits b. Encourage bowel habits/movements that resident has developed/adapted to 1) Time of day 2) Amount of privacy 3) Particular foods/fluids c. Observe/report/record resident's bowel movement 1) Amount 2) Consistency (firm-liquid-soft-hard) 3) Frequency d. Encourage diet habits 1) Fruits/vegetables 2) Fluid intake 3) Avoidance or limit of foods that cause constipation (cheese, sweets, milk products)	

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	e. Daily exercise/walking after meals	
5.8.7 Describe nurse aide's role in administration of enemas.	I. Nurse aides act in supportive roles to residents who receive enemas, oral and rectal laxatives 1. Enema a. Types/purpose b. Purpose 2. Laxatives a. Types/purpose b. Methods of administration 3. Role of nurse aide a. Assisting to bathroom/commode/bedpan b. Providing privacy c. Recording/reporting bowel elimination results d. Positioning of residents while qualified personal administers rectal treatments e. Nurse aides do not administer rectal treatments for constipation unless they have received a special inservice	
5.8.8 List alternative methods of bowel elimination.	J. Colostomy 1. Surgery to bring bowel to outside a. Cancer of the rectum b. Any disease of the intestines that could become cancerous c. Trauma to bowel that requires bowel be at rest to heal d. Any disease that results in obstruction of the intestines	Text assignment Lecture/discussion Trainex: "Colostomy Care"
5.8.9 Discuss the altered anatomy of a colostomy/ileostomy.	2. Opening called a stoma 3. Feces are eliminated through an opening called a stoma	Review anatomy and physiology of gastrointestinal system
5.8.10 Discuss the difference between a colostomy and an ileostomy.	K. Difference between a colostomy and an ileostomy 1. Different parts of the bowel are brought to the abdomen at different areas	Chart of diagram of ileostomy and colostomy.

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	a. Colostomy is an opening from a section of the colon into abdominal wall b. Ileostomy is an opening from a section of the ileum into the abdominal wall 2. The type of stool is affected a. Ileostomy: 1) The stool is more liquid because less water is absorbed by the body from the ileum 2) Control/regularity of stool is nearly impossible 3) Skin surrounding the stoma may become very irritated, even with correct cleaning b. Colostomy 1) The stool is more formed 2) Control of the stool is easier because water has been absorbed by the body 3) Skin surrounding the stoma requires a regimen of care which usually maintains good skin integrity	Lecture/discussion
5.8.11 Identify various ostomy appliances and methods used to apply them.	L. Ostomy appliance collecting device 1. A stoma bag has two specialized/sized openings a. Top - is secured at the stoma opening by adhesive material that fits outside of stoma - not directly on the stoma b. Bottom of stoma bag has an opening that allows for emptying of bag of stool contents without removing bag c. Bag is clamped at bottom	Examples of ostomy appliances Demonstration of application of an ostomy appliance

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
5.8.12 Discuss the major nursing problems that you should be aware of when giving care to a resident with a colostomy.	M. Major nursing problems aide should be aware of	
	1. Skin care:	Lecture/discussion
	a. Skin surrounding the stoma can become very irritated/redness to blisters	Examples of Kardex care plan of ostomy resident
	b. Cleaning of the area with soap and water and allowing to dry before applying new appliance	Pamphlets from American Cancer
	c. The skin surrounding the stoma should be examined each time the appliance is removed	
	1) For redness, skin ulcerations or skin changes (whitish)	
	2) Question resident about how skin feels	
	a) Burning	
	b) Soreness	
	c) Tenderness	
	d) Raw feelings	
	2. Functioning of the colostomy	
	a. Stool passed daily from the stoma	
	b. Sometimes a nurse will irrigate the colostomy daily with tap water. (This is similar to an enema given in the rectum.) If irrigation is done daily, some control can be attained over the amount of stool that is excreted throughout the day. Aides do not do this procedure	
	c. Residents need to be encouraged to drink fluids to prevent constipation which can lead to an obstruction of the intestine	
	3. Residents' feelings regarding a colostomy	Role play
	a. Anytime a person's normal body image is altered, the person has feelings concerning the change	Group discussion

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	b. Your role as an aide is to listen to the resident's feelings and not place judgment on their expressed thoughts c. Your attitude and reaction concerning the colostomy are very important. Always appear confident and not distressed by the site of the stoma or by the odor when emptying the appliance. This will help the resident accept his/her stoma and not be embarrassed by it d. If you hear or observe the resident as being unduly upset by the stoma, then this should be mentioned to your immediate supervisor e. Chronically ill residents do not accept changes in their routines readily 4. Aide's role in caring for resident with a colostomy a. A plan for the resident to care for colostomy and change the appliance will be developed by the registered nurse b. Report anything unusual c. Aides who assist with colostomy care are required to have special training	
5.9 Identify devices used in the urinary draining system.	IX. Urinary drainage system A. Urinary catheter 1. Tube inserted through the resident's urethra, and into the bladder per physician's order 2. Secure in the bladder by a small inflated balloon at the tip of the catheter 3. Catheter is taped to the inner thigh with no tension from catheter to thigh	Text assignment Examples of a catheter, tubing, drainage collecting bag Lecture/discussion Trainex: "Urinary Catheter-

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	4. The drainage system is always kept below the resident's bladder. Attach to lowest portion of bed frame	ization"
5.9.1 Discuss the nurse aide's role in a closed drainage system and its purpose.	B. Closed drainage systems - safety 1. Is a sealed system of connections of a catheter to drainage tube to a drainage bag 2. This system is kept sealed in order to prevent the introduction of an organism which could lead to an urinary tract infection 3. Sterile technique is used if any part of the system is disconnected. This means the use of sterile gloves and connecting ends must not be touched to outside surface 4. Care of the resident with a closed drainage system requires a. Residents prone to urinary tract infection b. System of drainage tubing and bag kept <u>below</u> level of bladder c. Keep system off floor, and tubing looped not kinked 5. Position tubing so there is a constant downward flow of urine. If not, urine will flow back into bladder which can lead to a urinary tract infection 6. Urinary catheters may be used for urinary inconsistence or retention 7. Leg bags are available to permit ambulation 8. Leg bags are secured to the thigh, and catheter tubing is straight but not tight 9. Tubing and bag must be kept off the floor	Demonstrate attachment Lecture/discussion

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
5.9.2 Demonstrate the ability to empty a drainage bag, measure the urine and reclose the system.	C. Emptying a catheter drainage bag 1. Assemble equipment 2. Wash your hands/apply gloves 3. Observe CDC precautions 4. Open the drain and let urine run into a graduate 5. Do not touch the end drain to hand, graduate, or other objects 6. Reclose drain 7. Measure the amount of urine 8. Rinse graduate with water 9. Wash hands 10. Record amount immediately on I-O sheet and report to charge nurse less than 200 cc amounts, foul smelling, cloudy or bloody urine.	Text assignment Skills Checklist #32 with catheter care
5.9.3 Describe procedure for catheter care.	D. Catheter care 1. Catheter care is for prevention of infection and good hygiene 2. Catheter care varies from institutions - check your policy on catheter care 3. Catheter care is a cleaning of the insertion site into the meatus opening (where the catheter meets the skin)	
5.9.4 Demonstrate the ability to give catheter care.	E. Catheter care 1. Assemble equipment 2. Wash your hands 3. Tell resident what you are going to be doing 4. Insure privacy and warmth 5. Put on disposable gloves being careful not to contaminate gloves prior to doing catheter care	Skills Checklist #32 with emptying bag Return demonstration

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	6. Cleanse area around meatus with cleansing solution used by your institution/ or what has been ordered to be used a. Gently separate the labia on female residents - wash front to back b. Gently pull back foreskin on male residents if necessary - replace after cleansing 7. Clean four inches of the catheter closest to the resident with cleansing solution 8. Apply antiseptic ointment following institutional routine 9. Discard equipment 10. Wash your hands 11. Record and report any unusual observations or changes	
5.9.5 Describe nurse aide's role in care of leg drainage bag.	F. Care of leg drainage bag 1. Ordered by physician for resident who is ambulatory 2. Check to make sure tubing is open - no kinks 3. Attach firmly to front of leg below level of urinary bladder - catheter tubing should not be tight/taunt 4. Drainage clamp should be securely fastened 5. Do routine catheter care as ordered 6. Check bag frequently for emptying	Lecture/discussion Demonstrate application of leg drainage bag
5.9.6 Identify the important observations that you will make regarding any resident that has a urinary catheter.	G. Observations of a resident with a urinary catheter 1. Urinary catheters should drain continuously 2. If there is no urine draining: a. Check the tubing for kinks b. Be sure resident is not lying on tubing	Lecture/discussion

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	c. Check the catheter itself for kinks d. Make sure tubing is not looped above the bladder e. Check the clamp on the tubing to be sure it is open f. Check that catheter is still secured to thigh - and no apparent dislodging has occurred h. If all of these points are negative, then notify immediate supervisor that there is no urine from the resident in question 3. While giving catheter care, you will want to observe if: a. There is any crusting at insertion site b. Any pus or unusual drainage c. Any sores or reddened areas present d. Any urine leaking around catheter e. Resident complains of bladder/lower abdominal pressure or spasms f. Report the above to immediate supervisor 4. Usually all residents with urinary catheters are on Intake and Output	
5.10 Discuss the major causes of bowel and bladder problems in residents in long term care facilities.	X. Bowel and Bladder training A. Causes of bowel and bladder problems: 1. Incontinence - loss of bowel and bladder control is not unusual in chronic illness and with the aging process 2. Health conditions that lead to incontinence are: a. Persons who have suffered a cerebro-vascular accident (CVA or stroke) b. Brain injuries c. Spinal cord injuries d. Bowel/bladder surgeries	Text assignment

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	e. Cancer f. Diseases which affect the nerves of the spine g. Women - result of child bearing	
5.10.1 Describe a bowel and bladder rehabilitation program.	B. Bowel and bladder training programs 1. Many residents with the problem of incontinence can be helped to regain bowel and bladder control with a planned program 2. Sometimes the resident suffers only incontinence of the bowels or the bladder. But, more often both are affected at the same time.	Examples of facility's bowel and bladder training program
	3. A routine for elimination is established by the interdisciplinary team and written on the care plan. It is very important that the resident's personal plan of elimination is carried out by the aide	Examples of care plans
	4. Each long term care facility will have a specific program that is followed by the staff. These may be different from facility to facility, but the basic goal is the same	Trainex: "Bowel and Bladder Training"
	C. The basic goal of bowel and bladder training is to: 1. Establish a regular pattern of elimination 2. Decrease the amount of times a resident is incontinent 3. Increase a resident's self-esteem by attaining control of their elimination 4. Decrease the chance of other problems; e.g., skin breakdown that can occur from continued incontinence 5. Preserve the integrity and function of the elimination systems	Lecture/discussion

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
5.10.2 Recognize the factors that are associated with incontinence that make management more difficult.	D. Factors that make management of incontinence more difficult 1. Over 65 years of age a. With age the urinary bladder and its opening weaken b. The nerves that carry messages to tell people when they have to urinate also weaken c. They usually have to urinate during the night d. Sometimes they involuntarily dribble urine e. Inability to empty bladder completely leads to urinary retention and then frequency f. Retention of urine often leads to urinary tract infection g. Level of mobility/and agility slows steps to bathroom 2. Emotional stress from: a. Moving to a nursing home b. Losing a loved one c. Being confined to bed d. Chronic illness 3. A concurrent illness 4. Inability to walk 5. Dependent for hygienic needs on others - need to be taken immediately when note urge 6. Speech problems 7. Hearing difficulties 8. Poor vision 9. Inability to remember and follow verbal commands	Lecture/discussion

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	10. Enlarged prostate gland in older males 11. Prolapsed urethra, vagina or rectum in females E. Residents who have two or more of these factors have difficulty in developing a successful program	
	F. Depending on the cause of incontinence 1. A resident may be unaware of the need to void or defecate 2. A resident may be aware, but unable to control or hold urination and/or defecation therefore important to respond to request for a bathroom or bedpan promptly 3. A resident may wish attention or be under emotional stress 4. No matter what the cause of incontinence, it is embarrassing for those who experience it a. Many incontinent people prefer to stay in their rooms b. Gradually they could lose interest in the people around them c. May deny conditions or feel too embarrassed to ask for assistance after the incontinence	Lecture/discussion
5.10.3 List the observations that an aide can make that will assist in the development of a bowel and bladder training program.	G. Observations to make concerning a resident who is incontinent 1. Observe how much contact he/she has with other people during the day 2. Talk with the person frequently 3. Is the resident incontinent when he/she is dressed in their clothes? When he/she is dressed in nightwear? 4. Observe how often the person urinates and the amount	Role play

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	5. Observe what times the person usually urinates during the day and night 6. Observe the amount of liquid that is taken orally 7. Observe the position of the person when urinating or having a bowel movement a. Observe the type/characteristic of urine or stool - report any abnormal signs 8. Observe the resident's emotional state when he/she is incontinent	
5.10.4 Discuss your role as an aide in a bowel and bladder training program.	H. Rehabilitation of a resident with bowel/ bladder incontinence 1. They are usually given a measured amount of fluids regularly throughout the day 2. They are placed on the commode or taken to the bathroom at regular, specific times throughout the day and night 3. Directed to bathroom before and after each meal, always upon awakening in the morning and at bedtime 4. They are never scolded like a child or treated negatively for incontinence. Praise is very important in the success of the program	
	I. Your role as an aide 1. Talk with the person. Tell them why they should drink fluids or go to the bathroom 2. Help resident remain clean and dry 3. Provide the specified amount of fluids and be sure they are taken orally 4. Record intakes accurately 5. Be sure resident is placed on a commode or taken to the bathroom at specified times	Role play Lecture/discussion

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	6. Report to immediate supervisor any observations regarding the resident and the success with the training program	
5.11 Describe nurse aide's role in application of heat and cold.	XI. Application of heat and cold A. Reasons 1. Promote healing - heat 2. Decrease pain - heat and cold B. Types 1. Whole body application a. Whirlpool b. Alcohol sponge 2. Local a. Hot water bottle b. Heat pad c. Ice pack d. Heat lamp C. Nurse aide's role 1. Does not apply without additional training 2. Observations and precautions a. Report 1) Complaints 2) Skin color changes 3) Other b. Observe 1) Placement heat lamp 2. Resident condition	
5.12 Describe benefits of TED Hose (antiembolism stockings).	XII. Antiembolism stockings A. Description 1. Long stockings of elasticized cotton 2. Full or knee length B. Purpose 1. Provide support - comfort 2. Smooth and compress distended veins 3. Help blood circulate without pooling	Lecture/discussion

Overview: This unit explores routine care procedures the nurse aide will be expected to perform. Included are vitals, intake and output, obtaining a specimen, urinary care and application of heat and cold.

OBJECTIVE	CONTENT	METHOD
	4. Reduce heart workload	
	C. Precautions	
	1. Need physician's order	
	2. Gently stretch over ankle and leg	
	3. Should fit snugly	
	4. Not too loose - and not too tight, it will impair circulation	
	5. Remove and reapply daily unless ordered more frequently	
	6. Do not let stockings become wrinkled	Demonstration
	7. Reapply if stockings become wrinkled	

6/92 kjb
1/93 kjb
7/93 kjb

Unit VI

Overview: This unit helps student explore the care needs of residents with specialized problems. Included are mental illness, the dementias, physical and mental disabled, terminally ill residents, and the death of a resident.

Teaching Time: 6-8 hours

OBJECTIVE	CONTENT	METHOD
6.0 Examine care needs of residents with specialized problems.	I. Specialized resident needs	Text assignment
	A. Interdisciplinary care plan	Lecture/discussion
6.1 Describe how the aide can use the interdisciplinary care plan in providing resident care.	1. Persons involved in developing plan	Examples of multidisciplinary care plans
	2. Purpose of plan	
	3. Content of plan	
	a. Problem identification	
	b. Goals - short and long term	
	c. Approaches for meeting goals	
	4. Revision - updating of plan	
	5. Nurse aide's role	
6.1.1 Discuss the care needs of the resident who has a cardiovascular condition.	B. Residents with conditions affecting cardiovascular system	
	1. Causes - inadequate functioning of heart, blood vessels and related organs of kidneys, liver, and lungs	
	a. Heart attacks	
	b. High blood pressure	
	c. Blood clots	
	2. Physiological signs/symptoms	
	a. Shortness of breath	
	b. Chest pain	
	c. Edema (swelling) of extremities	
	d. Poor circulation i.e. arteriosclerosis	
	C. Nursing care	Lecture/discussion
	1. Medications for disease/symptoms	
	2. Special diets	
	a. Low fat	
	b. Low salt	
	c. Low cholesterol	
	d. Fluid restriction	
	e. Combinations of above	
	3. Intake and output	
	4. Daily weights at set time of day, every other, or weekly	

Overview: This unit helps student explore the care needs of residents with specialized problems. Included are mental illness, the dementias, physical and mental disabled, terminally ill residents, and the death of a resident.

OBJECTIVE	CONTENT	METHOD
	5. Slower to heal when injured - especially feet a. Protect from injury - always wear shoes/ slippers b. Trimming nails requires a physician or podiatrist skill 6. Careful observation and reporting of symptoms/changes in physical or metal condition	
6.1.2 Describe the care needs of the resident with respiratory problems.	D. Residents with conditions affecting the respiratory system 1. Common causes - interference with breathing, exchange of air in lungs a. Allergies b. Smoking c. Infections d. Obesity e. Paralyzed/quadraplegic 2. Diseases a. Asthma b. Emphysema c. Bronchitis d. Cancer e. Chronic pneumonia's f. Autoimmune diseases, includes AIDS, ALS, multiple sclerosis or muscular dystrophy 3. Problems/symptoms a. Labored breathing b. Coughing c. Blueness of skin (cyanosis) d. Thick secretions or copious amounts phelgm e. Pursed lips f. Rapid/shallow breathing > 28/min. 4. Interventions a. Medications b. Oxygen c. Respiratory treatments d. Positions - as upright as possible/sitting facilitates air exchange	Lecture/discussion

Overview: This unit helps student explore the care needs of residents with specialized problems. Included are mental illness, the dementias, physical and mental disabled, terminally ill residents, and the death of a resident.

OBJECTIVE	CONTENT	METHOD
	e. Quiet-non-anxiety provoking environment f. Observe/report changes in condition and symptoms.	
6.1.3 Discuss the care needs of residents with nutritional problems.	E. Residents with nutritional imbalances 1. Common causes - conditions which compromise nutritional intake or utilization of nutrients a. Hereditary - diabetic b. Congenital - bowel insufficiency c. Physically compromised 1) Swallowing dysfunction 2) Poor dentition d. Mentally compromised 1) Depression 2) Anorexia 2. Problems/symptoms a. Underweight b. Malnourished c. Muscle wasting d. Chronic sickness e. Vomiting/diarrhea 3. Other GI conditions a. Cancer b. GI tract diseases c. Irritable bowel syndrome d. Enzymes deficient for complete digestion	
6.1.3.1 Describe symptoms of diabetes.	3. Diabetics a. Definition/causes 1. Inability to convert/utilize the nutrient-glucose 2. Pancreas inability to provide adequate amounts of insulin in order to convert glucose for utilization in the body 3. Hereditary or acquired disease 4. Obesity	Handout: Diabetic Coma vs. Insulin reaction

Overview: This unit helps student explore the care needs of residents with specialized problems. Included are mental illness, the dementias, physical and mental disabled, terminally ill residents, and the death of a resident.

OBJECTIVE	CONTENT	METHOD
6.1.3.2 List the signs/symptoms of diabetic coma.	b. Symptoms/signs of diabetic coma 1. Flushed/warm and dry skin 2. Nausea/vomiting 3. Frequent urination 4. Increased thirst 5. Fruity/sweet breath 6. Sleepy - lethargic 7. Mood change - quiet to angry 8. Deep/labored breathing	
6.1.3.3 Identify the special care needs of a resident with diabetes.	c. Prevention/treatment 1. Monitor/observe resident dietary regimen and compliance 2. Monitor blood/urine tests as ordered - report/record - done by licensed nurse only 3. Supportive cares - quite environment, fluids 4. Insulin will be given to restore glucose levels to safe levels - done by licensed nurse only	
6.1.3.4 List the symptoms of an insulin reaction.	d. Signs/symptoms of insulin reaction 1. Sweaty - cool skin 2. Hungry 3. Jittery- restlessness 4. Headache 5. Change in vision - double 6. Confused 7. Shallow breathing 8. Weakness/loss of balance	
	e. Prevention/treatment 1. Monitor/observe resident dietary regimen and compliance 2. Monitor blood/urine tests as ordered - report/record - Licensed nurse only 3. Supportive cares/safe environment 4. Nutritional supplementation needed immediately with foods/juice which has sugar and protein	

Overview: This unit helps student explore the care needs of residents with specialized problems. Included are mental illness, the dementias, physical and mental disabled, terminally ill residents, and the death of a resident.

OBJECTIVE	CONTENT	METHOD
	f. Aide's responsibility 1. Report symptoms of either condition to nurse in charge 2. Assist nurse in charge in monitoring residents response to interventions 3. Observe - report residents compliance/ adequacy with nutritional intake g. Complications of diabetes 1. Kidney failure 2. Heart disease 3. Circulation a. Slow healing - aides do not cut nails break sores/blisters, and should report skin conditions to charge nurse 4. Eye disease - blindness	
6.1.4 Identify the special needs of residents with muscular-skeletal conditions.	F. Residents with neuro-muscular conditions 1. Causes/conditions affecting a. Congenital b. Aging c. Accidents d. Diseases 1) Parkinson 2) C.V.A. 3) Autoimmune disease (M.S., ALS) 4) Paralysis 5) Brain disorders/tumors 2. Problems/signs a. Paralysis b. Ambulation limits c. Communication/slurred speech/ inappropriate d. Coordination/loss balance e. Muscle atrophy f. Joint deformity/contracture 3. Interventions a. Supportive care - assist activity b. Medications	Lecture/discussion Handout

Overview: This unit helps student explore the care needs of residents with specialized problems. Included are mental illness, the dementias, physical and mental disabled, terminally ill residents, and the death of a resident.

OBJECTIVE	CONTENT	METHOD
	c. Exercise/ROM d. Assistive devices 1) Artificial limbs 2) Canes/walkers/crutches 3) Spelling/picture board	
6.2 Describe the care needs for residents who have dementia.	II. Dementia Disorders A. Define dementia B. Causes 1. Alzheimer's Disease 2. Multi-Infarc Dementia 3. Reversible dementia (delirium)	Lecture/discussion Reference material "Abbe Center Program" available at all area colleges
6.2.1 Investigate the stages and behaviors often seen in residents with Alzheimer's.	C. Alzheimer's - most common 1. Stages of Alzheimer's a. Forgetfulness b. Later - confusion c. Ambulatory dementia d. Endstage 2. Common behavior problems a. Cover-up of memory loss b. Losing/hiding objects c. Protective of own space d. Wandering e. Repeat questions/actions f. Changed sleep patterns g. False ideas/beliefs h. Inappropriate sexual behavior i. Territoriality 3. Catastrophic reactions a. Definition b. Agitation c. Combativeness d. Confusion e. Fearfulness g. Night waking 4. Situations that increase rise of catastrophe a. Tiredness (fatigue)	

Overview: This unit helps student explore the care needs of residents with specialized problems. Included are mental illness, the dementias, physical and mental disabled, terminally ill residents, and the death of a resident.

OBJECTIVE	CONTENT	METHOD
	b. Too much stimulation c. Changes in persons who provide care d. Demands from care givers/family are too great e. Negative reactions or feedback from care-givers f. Physical stress, i.e., illness, medications, discomfort, hunger, full bowel or bladder	
6.2.2 Identify appropriate interventions when caring for Alzheimer's resident.	D. Interventions - care of resident 1. Eliminate/reduce environmental stress 2. Assist with loss of ability to think/ plan 3. Give unconditional positive responses 4. Allow for lowered stress threshold 5. Communications with resident a. Verbal 1) Short words 2) Simple sentences 3) No pronouns - only nouns 4) Begin each session by identifying self b. Speech style 1) Speak slowly 2) Say individual words clearly 3) Keep pitch of voice at normal level and tone - nonthreatening 4) If you ask a question - wait for a response 5) Ask only one question at a time 6) If you repeat, repeat it <u>exactly</u> 7) Use self - include humor when possible 8) If resident loses train of thought, repeat his/her last few words to assist with recall	Lecture/Discussion

Overview: This unit helps student explore the care needs of residents with specialized problems. Included are mental illness, the dementias, physical and mental disabled, terminally ill residents, and the death of a resident.

OBJECTIVE	CONTENT	METHOD

c. Nonverbal
   1) Convince self nonverbal can be felt anywhere in room
   2) Use proper nonverbal gestures
d. Specifics
   1) Stand in front
   2) Maintain eye contact
   3) Move slowly
   4) If resident starts moving, don't stop, move with them
   5) Use overemphasis and exaggerated facial expressions
e. General guides
   1) Listen actively - if you don't understand say so - ask for repeat
   2) Assume capability for insight
   3) Report all phrases and nonverbal techniques used consistently
   4) If you say you will do something, DO IT
   5) If you need to intervene in resident-to-resident exchange, do it quickly

6. Use validation/reminiscence not orientation
   a. Avoid reality orientation with these residents
   b. Don't confront wrong beliefs
   c. Review of past experiences (reminiscence) may promote security
   d. Provide assurance of safety
   e. Provide visual cues
7. Provide lower stress
   a. Routine
   b. Rest periods
   c. Reduce stimuli - move to quieter place, etc.
   d. Alternate low-high stress; e.g., quiet time after bath

Overview: This unit helps student explore the care needs of residents with specialized problems. Included are mental illness, the dementias, physical and mental disabled, terminally ill residents, and the death of a resident.

OBJECTIVE	CONTENT	METHOD
	8. Evaluation of care a. Keep records regarding 1) Sleep hours 2) Weight 3) Food intake 4) Falls 5) Stress related incidents	
6.3 Discuss the care needs of residents with mental retardation.	III. Mental Retardation A. Classification 1. Low normal 2. Mild 3. Moderate 4. Severe 5. Profound B. Behavior of mentally retarded 1. Difficulty comprehending 2. Difficulty problem solving 3. Communication problems a. Speaking b. Reading 4. Problems socializing 5. Often have physical limitations a. Clumsy b. Drooling c. Poor manual dexterity 6. Spastic motions 7. Aggressive actions 8. Short attention span 9. Poor judgment C. Care for resident 1. Follow interdisciplinary plan 2. Use proper speech 3. Encourage independence 4. Help with socialization with other residents	Lecture/discussion Lecture/discussion

Overview: This unit helps student explore the care needs of residents with specialized problems. Included are mental illness, the dementias, physical and mental disabled, terminally ill residents, and the death of a resident.

OBJECTIVE	CONTENT	METHOD
	6. Teach/assist to do daily living skills 7. Approach and respond normally	
6.4 Describe nurse aide's role in caring for mentally ill.	IV. Mental illness A. Definition B. Behaviors 1. Suspicious/paranoid 2. Anxious/nervous 3. Fearful 4. Depressed 5. Withdrawn/noncommunicative 6. Excitable/hyperactive 7. Out of touch with reality a. Delusional - wrong ideas b. Hallucinations C. Care of resident with mental illness 1. Follow interdisciplinary plan 2. Be consistent 3. Avoid power struggles 4. Try to understand behavior - look for cause/effect 5. Assist with daily living needs - encourage self care 6. Treat with respect 7. Use proper speech	Lecture/discussion
6.5 Describe nurse aide's role in dealing with difficult behavior regardless of cause.	V. Difficult behavior A. Definition 1. Verbal 2. Physical B. Determine cause and effect C. Diffuse situation - prevention best cure	Lecture/discussion
6.6 Discuss your feelings and society's feelings concerning the concept of death and dying.	VI. The dying resident's needs A. Feelings and attitudes concerning dying 1. Residents in long term care facilities may have chronic diseases	Text assignment Lecture/discussion

Overview: This unit helps student explore the care needs of residents with specialized problems. Included are mental illness, the dementias, physical and mental disabled, terminally ill residents, and the death of a resident.

OBJECTIVE	CONTENT	METHOD
	2. People differ widely in their ability and willingness to verbalize their feelings about death 3. Society as a whole tends to avoid meaningful discussions of death 4. Spiritual and religious concepts are important 5. Nurse aide can contribute by providing support with verbal/non-verbal feedback B. Aide's feelings about dying 1. Types of reactions 2. Recognize your own feelings 3. Methods of handling feelings 4. Appropriateness of feelings 5. Past experiences/closeness to someone dying	Trainex: "Death and Dying",
6.6.1 Discuss the various reactions/ behaviors persons may have when facing death.	C. Behaviors the resident may exhibit when he/she suspects that death is a reality 1. May question everyone about his/her chances of recovery 2. May be afraid to be alone 3. May ask a lot of questions 4. May complain frequently 5. May make unreasonable requests 6. May withdraw from other people 7. May cry and be sad 8. May be very cheerful and not believe that he/she is dying 9. Your role as an aide is to: a. Have an awareness of patients condition, and what patient knows b. Listen c. Provide comfort and understanding d. Encourage resident to talk about illness/ feelings of dying e. Be truthful f. Sit with resident frequently throughout day if resident is confined to bed	

Overview: This unit helps student explore the care needs of residents with specialized problems. Included are mental illness, the dementias, physical and mental disabled, terminally ill residents, and the death of a resident.

OBJECTIVE	CONTENT	METHOD
6.6.2 Identify and discuss the special needs of a dying resident and discuss your role in relation to these needs.	D. Special needs of a dying person 1. Follow interdisciplinary care plan 2. Keep room well ventilated and lighted and at a comfortable temperature 3. Change resident's position often, to a position of comfort/every 2-3 hrs. 4. Prevent decubitus by positioning and cleanliness of patient and bed linens 5. Speak in a normal tone 6. Hearing is the last of the senses to leave, things you wouldn't say to others should not be said. 7. Respect resident's need for spiritual support. Find out if there are any special rules concerning religion or culture. 8. Encourage fluids and foods that the resident likes. Don't force patients to eat, but offer sips of fluids every hour 9. Report any changes in the resident to immediate supervisor 10. Give mouth care frequently/every 2-3 hrs with turning patient 11. Give good nasal care, for patients on oxygen vaseline inside nares	Lecture/discussion
6.6.3 Describe the hospice concept and its basic purposes.	E. Hospice Care 1. A health care service offered by some hospitals and extended care facilities 2. Is designed for the care of persons having terminal illnesses and family members helping them 3. Works with the family in the goals of assisting them through the grieving process 4. Focuses attention only on the needs and care of the terminally ill 5. Offers day and/or night care, home care and bereavement care, in addition to 24 hour inservice care	Lecture/discussion

Overview: This unit helps student explore the care needs of residents with specialized problems. Included are mental illness, the dementias, physical and mental disabled, terminally ill residents, and the death of a resident.

OBJECTIVE	CONTENT	METHOD
	6. Respite care and/or palliative care 7. Provides emotional support and physical care and comfort for people for whom medical treatment are no longer being actively pursued 8. The goal of a hospice unit is to allow the person a natural death that is as comfortable and dignified as possible 9. Hospice groups plan interdisciplinary care of resident	
6.6.4 List the signs of approaching death.	F. Signs of approaching death 1. Blood circulation slows down. Resident's hands and feet are cold to the touch. If resident is conscious, may complain of being cold. 2. Mottling/blueness to extremities and around lips 3. Pupils/eyes non-responsive to light 4. Cold perspiration is common 5. Muscle control decreases resulting in sagging jaw or lips, limp extremities 6. Respirations slow and become labored 7. "Death rattle" may be audible 8. Pulse is rapid and weak 9. Pain is not usually severe 10. Incontinence of bowel and bladder may occur 11. Level of consciousness may change (e.g., hallucinations, confusion) 12. If you notice these signs, notify immediate supervisor	Lecture/discussion
6.6.5 Recognize the reactions/ feeling of the immediate family/ friends and other residents.	G. Immediate family's needs 1. Resident's family may wish to spend a lot of time with person 2. Remember to insure a family's need for privacy and spiritual support	Role play Small group discussion

Overview: This unit helps student explore the care needs of residents with specialized problems. Included are mental illness, the dementias, physical and mental disabled, terminally ill residents, and the death of a resident.

OBJECTIVE	CONTENT	METHOD
	3. Take care of the resident just as you usually would if he/she was not dying. Don't wait for family to leave before doing his/her routine cares. 4. Answer family's questions to your ability. If you can't answer the questions, refer them to your immediate supervisor. 5. Make sure family is comfortable while they are with the resident. 6. Be courteous, understanding and thoughtful of the family's feelings 7. Be aware of any designated area the family may retreat to for privacy	
6.6.6 Define postmortem care.	H. Postmortem care 1. Means: after death 2. No care should be started until immediate supervisor tells you to begin 3. After death, the body must be treated with respect and must be given care gently 4. Postmortem care is an emotional time for the staff and family 5. Postmortem care may vary from facility to facility - follow the facilities procedure 6. If family members are present, they should wait outside until the doctor has examined the body and pronounced the resident dead 7. Postmortem care should be done before rigor mortis sets in. Rigor mortis means the body and limbs become stiff 8. Postmortem care is done to help the mortician prepare the body so that the body appears as normal as possible	Text assignment Lecture/discussion
6.6.7 Discuss procedure for postmortem care.	I. Postmortem care 1. Assemble equipment 2. Wash hands	

Overview: This unit helps student explore the care needs of residents with specialized problems. Included are mental illness, the dementias, physical and mental disabled, terminally ill residents, and the death of a resident.

OBJECTIVE	CONTENT	METHOD
	3. Insure privacy. Greet family and ask if they would like to leave the room while you prepare the body for mortician. 4. Position body in supine position 5. Close eyes if they are open by pulling down gently on the lashes 6. Replace dentures if possible. If not, place in clean denture cup labeled with resident's name. Place on pillow. 7. Clean and close the mouth 8. Bathe body, clean finger nails, put on clean gown, pajama top or shroud 9. Comb hair. Shave resident if needed. 10. If catheter is to be removed or clean dressing are needed, report to charge nurse 11. Remove personal belongings, give to family. Record. If no family is present, label belongings, give to charge nurse, record. 12. Fold arms over abdomen 13. Bed linens are to be clean and wrinkle free 14. Position body with one pillow under head, top sheet neatly folded at chest level as if body is prepared for sleep 15. Attach legible I.D. bracelet to wrist or ankle or follow facility procedure 16. If resident wore glasses, place then next to the denture cup on the pillow 17. Assist mortician to gently move body to mortuary stretcher 18. Remove bed linens and supplies from room to prepare for cleaning. If housekeeping is not immediately available, place a clean bedspread on the bed so that the unmade bed is not a constant reminder to other residents	

7/92 kjb
7/93 kjb

NURSE AIDE
Unit II

Skills Checklist #1
Hand Washing Technique

Equipment needed: Soap, sink, running water, paper towels, wastebasket.

Name _____
Passed _____ Needs More Practice _____

____ 1. Assemble equipment.

____ 2. Wet hands completely.

____ 3. Apply soap.

____ 4. Hold hands lower than elbows.

____ 5. Work up a good lather.

____ 6. Clean your nails.

____ 7. Wash hands by using a rotating, rubbing motion, rubbing palms and between fingers for 15 seconds.

____ 8. Wash at least two inches above wrist.

____ 9. Rinse well.

____ 10. Dry hands thoroughly with paper towel and discard.

____ 11. Take dry paper towel and turn off faucet.

____ 12. Discard paper towel in wastebasket.

Comments:

Instructor's Signature _____ _____ Date _____

NURSE AIDE
Unit II

Skills Checklist #2
Making a Closed and Open Bed

Equipment: Sheets, pillowcases, blankets, bedspread, drawsheet if needed.

Name _____
Passed _____ Needs More Practice _____

____ 1. Assemble all linen.

____ 2. Remove dirty linen and put in appropriate place.

____ 3. Wash hands.

____ 4. Adjust bed to high position.

____ 5. Be sure mattress is correctly positioned on bed. If not pull mattress to top.

____ 6. Apply mattress pad.

____ 7. Apply bottom sheet correctly (flat or fitted).

____ 8. Miter top corners of flat sheet. Tuck tightly if fitted sheet.

____ 9. Apply plastic draw sheet, if necessary.

____ 10. Cover plastic draw sheet with appropriate linen.

____ 11. Apply top sheet correctly.

____ 12. Apply blanket and/or spread.

____ 13. Miter all corners.

____ 14. For open bed, fan-fold top sheet and spread toward the foot of the bed.

____ 15. Put pillowcase on pillow, using correct technique-do not hold under chin.

____ 16. Remove dirty linen from room and place in laundry.

____ 17. Straighten and clean resident's unit.

____ 18. Wash hands.

Comments:

Instructor's Signature_____ Date _____

*This skill should be completed in 15 minutes.

NURSE AIDE
Unit II

Skills Checklist #3
Making an Occupied Bed After the Resident's Bath

Equipment: Sheets, drawsheet if required, pillowcases, blankets, bedspread.

Name _____
Passed _____ Needs More Practice _____

____ 1. Assemble necessary linen.

____ 2. Wash your hands.

____ 3. Insure the resident's privacy.

____ 4. Tell the resident you will be making his/her bed.

____ 5. Lower back rest or knee rest until bed is flat. (Check first with your supervisor. Some residents cannot tolerate a flat position.)

____ 6. Be sure side rail is elevated on the opposite side of the bed from where you are working.

____ 7. Position pillow according to resident's tolerance level.

____ 8. Loosen all linen.

____ 9. Remove the top linen after covering resident with bath blanket.

____ 10. Maintain resident's privacy.

____ 11. Check the position of the mattress. Pull it up if necessary.

____ 12. Ask the resident to turn on his/her side toward the raised side rail.

____ 13. Fold the dirty bottom sheets toward the resident and tuck them against his/her back.

____ 14. Apply clean bottom sheet on the exposed half of the bed using the correct technique.

____ 15. Apply draw sheet if necessary.

____ 16. Raise the side rail on your side of the bed.

____ 17. Ask the resident or assist the resident to roll toward you, over the "hump", onto clean sheets. Go to the other side of the bed.

___ 18. Remove dirty bottom sheets. Pull clean linen from under resident.

____ 19. Tighten all linen before tucking it under mattress.

(Turn Page)

Skills Checklist #3 continued

____ 20. Change pillowcase and position pillow under resident's head.

____ 21. Apply top sheet and remove the bath blanket, keeping resident from being exposed.

____ 22. Apply blankets and/or spread. Miter corners top sheet and spreads.

____ 23. Position resident comfortably. Elevate head of bed if requested.

____ 24. Reposition resident's call button.

____ 25. Remove dirty linen and place in appropriate place.

____ 26. Straighten and clean resident's unit.

____ 27. Wash hands.

Comments:

Instructor's Signature_____ Date _____

NURSE AIDE
Unit II

Skills Checklist #4
Obstructed Airway: Conscious Adult

Name _____
Passed _____ Needs More Practice _____

____ 1. Determine if resident can cough or speak.

____ 2. Determine airway obstruction - ask "Are you choking?"

If obstructed, use Heimlich Maneuver

____ 3. Stand behind resident.

____ 4. Wrap arms around resident's waist.

____ 5. Make a fist with one hand, place thumb side against resident's abdomen midline slightly above navel and well below rib cage.

____ 6. Grasp fist with other hand.

____ 7. Press into victim's abdomen with quick upward thrusts.

____ 8. Each thrust should be distinct and delivered with intent of relieving obstruction.

____ 9. Repeat thrusts until object expelled or victim becomes unconscious.

____ 10. If victim becomes unconscious, call 911 (activate EMS system).

Unconscious

____ 11. Use tongue/jaw lift to open mouth.

____ 12. Perform finger sweep.

____ 13. Open airway using head tilt/chin lift.

Comments:

Instructor's Signature_____ Date _____

NURSE AIDE
Unit II

Skills Checklist #5
Safely Applying Restraints

Equipment: Restraints that have been approved by nurse, pads as required.

Name _____
Passed _____ Needs More Practice _____

____ 1. Check with nurse regarding order and type of restraint to be applied.

____ 2. Assemble equipment.

____ 3. Wash hands.

____ 4. Determine if help is needed in applying restraints; if it is, get help.

____ 5. If appropriate take the resident to the bathroom before applying.

____ 6. Calmly explain to the resident what you are going to do.

____ 7. Properly and comfortably position resident.

____ 8. Pad any bony prominences.

____ 9. Follow the correct procedure for the type of restraint being applied.

____ 10. Be sure restraints are secured in proper places; not to side rails but to the frame of the bed.

____ 11. Check to make sure restraints are not too tight-check circulation. Allow as much movement as possible.

____ 12. Leave resident as comfortable as possible.

____ 13. Wash hands.

____ 14. Record, if required by your facility.

____ 15. Check restraints as often as required and remove as required.

Comments:

Instructor's Signature_____ Date _____

NURSE AIDE
Unit II

Skills Checklist #6
Safely Using Mechanical Lifts

Equipment: Mechanical Resident Lift and Sling

Name _____
Passed _____ Needs More Practice _____

____ 1. Assemble equipment.

____ 2. Secure the assistance needed. Two persons required.

____ 3. Wash hands.

____ 4. Explain to the resident what you are going to do and how he/she can assist. Provide privacy.

____ 5. Position chair next to bed with back of chair in line with headboard; if using a wheel chair, lock the brakes.

____ 6. Slide the sling under the resident, by turning the resident from side to side.

____ 7. Be sure all locks and straps are fastened securely and correctly.

____ 8. Explain to the resident what you will be doing, have the resident fold arms across chest; then by using crank, slowly raise the resident.

____ 9. Have assistant guide resident's legs and lower resident carefully into position into the chair.

____ 10. Remove equipment and properly position and secure resident in chair.

____ 11. Wash hands.

Comments:

Instructor's Signature_____ Date _____

NURSE AIDE
Unit II

Skill Checklist #7
Lifting and Moving a Resident in Bed

Name _____
Passed _____ Needs More Practice _____

____ 1. Ask for help if necessary.

____ 2. Wash your hands.

____ 3. Tell the resident what you will be doing. Fold back sheet.

____ 4. Ensure resident's privacy.

____ 5. Lock wheels on bed.

____ 6. Remove pillows and place at head of bed.

____ 7. If two aides, position one aide on each side of the bed.

____ 8. Stand with back straight, knees bent, turned slightly toward the head of the bed. Feet 12 inches apart.

____ 9. Ask resident to bend knees, put feet flat on bed and push when asked.

____ 10. Put one arm under the resident's nearest shoulder.

____ 11. Put other arm under resident's buttock.

____ 12. Other assistant is doing the same. The leader will then say when to move. e.g. 1-2-3 pull.

____ 13. Slide resident up by straightening your knees.

____ 14. Move resident gently to prevent pain.

____ 15. Replace covers.

____ 16. Wash hands.

____ 17. Report any unusual observations to supervisor.

Comments:

Instructor's Signature_____ Date _____

NURSE AIDE
Unit II

Skills Checklist #8
Using a Gait Belt

Name _____
Passed _____ Needs More Practice _____

____ 1. Explain procedure to resident--decrease anxiety and increase cooperation.

____ 2. Apply belt while resident is in a comfortable position.

____ 3. Make sure it is applied tightly enough to prevent it from riding up and down on the resident's body but loosely enough so you can grasp firmly.

____ 4. If the resident has a weak side, make sure the stronger side is facing destination.

____ 5. Stand in front of the resident maintaining the normal curve of your spine, knees slightly bent, and feet approximately 12 inches apart. If the resident has a weak side, the weak foot should be supported by the inside of your foot to prevent the restraint from slipping.

____ 6. Learn forward and grasp gait belt on both sides. If the resident is able, encourage him/her to participate by pushing up on chair arms, bearing weight, and pivoting.

____ 7. Gently lift the resident and guide him/her to the goal. Give frequent verbal cues to encourage resident participation.

____ 8. When the destination has been reached, gently lower and encourage the resident to use his/her arms to reach toward destination and bear weight.

____ 9. Once the resident is situated, the belt may be removed.

Things to remember:

____ 1. If the resident is heavy or has difficulty bearing weight, consider using a hoyer lift transfer.

____ 2. It is possible for two people to use if each one stands on opposite sides of the resident.

____ 3. The gait belt can be used to assist with walking. It can serve as a handle to grasp if the resident begins to fall to help prevent the fall or control the resident's descent.

(Turn page)

Skills Checklist #8 continued

____ 4. Never allow the resident to pull up by grasping the belt while you are wearing it.

The gait belt can provide assistance and allow the resident's maximum independent function and help to provide safety to the resident and caregiver.

Comments:

Instructor's Signature_____ Date _____.

Provided by Iowa Foundation for Medical Care.

NURSE AIDE
Unit II

Skills Checklist #9
Transferring a Resident from Bed to Chair

Equipment: Resident's robe and slippers, chair or wheel chair.

Name _____
Passed _____ Needs More Practice _____

____ 1. Tell resident what you will be doing: get help if necessary.

____ 2. Wash hands. Ensure resident's privacy.

____ 3. Lock wheels on bed.

____ 4. Position chair at bedside on resident's weak (affected) side so resident can be moved toward stronger (unaffected) side.

____ 5. Place bed in low position.

____ 6. Assist resident to edge of the bed nearest chair.

____ 7. Raise back rest so resident is in sitting position.

____ 8. Lower the side rails.

____ 9. Assist resident so he/she is sitting on the side of the bed. Feet should be dangling over side of bed.

____ 10. Put on resident's robe and slipper - if needed gait (transfer belt).

____ 11. Allow resident to sit on edge of bed long enough to adjust to change in position.

____ 12. Stand facing resident. Put your hands under transfer belt and assist him/her to stand at bedside.

____ 13. Pivot turn or assist the resident in turning.

____ 14. Slowly help the resident lower into the chair. Place in good body alignment.

____ 15. Fasten safety straps if needed. Place call bell within reach.

____ 16. Position resident comfortably.

(Turn page)

Skills Checklist # 9 continued

____ 17. Wash your hands.

____ 18. Check resident frequently while he/she is up in chair.

Comments:

Instructor's Signature_____ Date _____

NURSE AIDE
Unit II

Skills Checklist #10
Positioning Resident in Bed

Name _____
Passed _____ Needs More Practice _____

Supine Position

____ 1. Wash hands.

____ 2. Explain to the resident what you are doing.

____ 3. Gently move resident to center of bed.

____ 4. Turn resident onto his/her back.

____ 5. Position head in straight line with the spine.

____ 6. Elbows are slightly bent, hands resting at resident's side, toes pointing upward, legs are straight (do not allow legs to rotate outward).

____ 7. Position pillow under resident's head.

____ 8. Wash hands.

Side Lying Position

____ 9. Wash hands.

____ 10. Tell resident what you are going to do.

____ 11. Provide resident with privacy.

____ 12. Move resident to the side of the bed where his/her back will be positioned.

____ 13. Gently cross resident's leg closest to you over leg furthest away from you.

____ 14. Head should be positioned in line with spine, body in straight alignment, one knee may be flexed.

____ 15. Position pillow under head, at back, between legs, and if available under arms.

____ 16. Wash hands.

Comments:

Instructor's Signature_____ Date _____

NURSE AIDE
Unit II

Skills Checklist #11
Ambulation

Name _____
Passed _____ Needs More Practice _____

____ 1. Check nursing plan or with supervisor to make sure resident has the strength and balance to ambulate and to see if recommended procedure.

____ 2. Explain to resident what you are going to do as well as how they can assist.

____ 3. Get help if needed.

____ 4. Assist resident to sitting position if in bed, allow resident to gain balance when in this position.

____ 5. Assist in dressing and putting on appropriate shoes...need firm support with rubber heels.

____ 6. Place gait belt around resident's waist. Make sure it is tight enough not to slip but loose enough for you to get hands under and support.

____ 7. Stand facing resident with hands under gait belt.

____ 8. Assist resident to stand, allow resident to gain balance before walking.

____ 9. To ambulate, stand at side or slightly behind the resident, giving support by using the belt...helps resident control center of gravity.

____ 10. If the resident has a side that is affected by weakness, injury, or paralysis the aide should stand on weak (affected) side unless care plan suggests another method.

____ 11. Walk slowly. Observe for tiredness, weakness, etc. Let resident rest if necessary.

____ 12. Return resident to bed or to chair. Report/Record.

If a resident becomes weak, falls, or loses balance; the aide should gently ease the resident to the floor. Stay with the resident and call for help. Before the resident is moved THEY MUST BE EXAMINED BY THE NURSE FOR INJURY.

Instructor's Signature_____ Date _____

NURSE AIDE
Unit II

Skills Checklist #12
Range of Motion - Lower Extremity

Name _____
Passed _____ Needs More Practice _____

____ 1. Wash hands.

____ 2. Explain to resident what you are going to do.

UPPER EXTREMITY

Shoulder

____ 3. Expose arm to shoulder.

____ 4. Position hands correctly--support arm.

____ 5. Raise arm above head as far as possible - keep elbow straight. Return. (Repeat 5-10 times)

____ 6. Keep elbow straight and move away from body. Return. (Repeat 5-10 times.)

____ 7. Roll arm inward - outward (movement at shoulder joint). (Repeat 5-10 times.)

Elbow

____ 8. Position hands correctly--lower and upper arm.

____ 9. Bend elbow as far as possible - straighten completely. (Repeat 5-10 times.)

Wrist

____ 10. Position hands correctly--support lower arm and hand.

____ 11. Bend hand down as far as possible, bend hand up as far as possible. (Movement at wrist.) (Repeat 5-10 times.)

____ 12. Bend hand from side to side - toward little finger, then toward thumb. (Movement is at wrist.) (Repeat 5-10 times.)

____ 13. Make a circle with the hand - moving at wrist (both clockwise and counter-clockwise.) (Repeat 5-10 times.)

(Turn page)

Skills Checklist #12 continued

Hand

____ 14. Bend fingers to make a fist - fully straighten fingers. (Repeat 5-10 times.)

____ 15. Spread thumb and fingers apart (keeping all straight) - bring them back together again. (Repeat 5-10 times.)

____ 16. Bend fingers at base knuckle joint only; keep fingers straight; fully open the hand. (Repeat 5-10 times.)

____ 17. Bend thumb and place it against palm. Pull it across toward little finger, pull it back. (Repeat 5-10 times.)

____ 18. Place thumb in front of index finger - move thumb perpendicular (right angle) away from hand and move it back. (Repeat 5-10 times.)

____ 19. Touch the tip of the thumb to the index finger. Open hand wide. Touch tip of thumb to each of the other fingers, opening hand wide between touches. (Repeat 5-10 times.)

LOWER EXTREMITY

Hip

____ 20. Expose leg to hip.

____ 21. Position hands correctly--support leg securely.

____ 22. Move leg up off surface as far as possible - keep knee straight. Return. (During movement keep opposite knee bent, foot flat on surface.) (Repeat 5-10 times.)

____ 23. Move leg out to side as far as possible. Return to start. (Repeat 5-10 times.)

____ 24. Roll leg in, roll leg out (movement at hip joint). (Repeat 5-10 times.)

Knee

____ 25. Position hands correctly--support upper and lower leg.

____ 26. Bend knee as far as possible - straighten completely. (Repeat 5-10 times.)

(Turn page)
Skills Checklist #12 continued

Ankle

____ 27. Position hands correctly--support lower leg and foot.

____ 28. Bend toes and foot as far as possible, bend toes and foot down as far as possible (movement at ankle). (Repeat 5-10 times.)

____ 29. Move foot from side to side. (Repeat 5-10 times.)

____ 30. Make circles with foot (clockwise and counter-clockwise - movement occurs at ankle). (Repeat 5-10 times.)

Foot

____ 31. Position hands correctly--support leg.

____ 32. Bend toes down only (curl under); bend toes up only. (Repeat 5-10 times).

____ 33. Spread toes apart. (Repeat 5-10 times.)

____ 34. Wash hands.

Comments:

Instructor's Signature_____ Date _____

NURSE AIDE
Unit III

Skills Checklist #13
Assisting With Oral Hygiene

Equipment: Toothbrush, toothpaste, emesis basin, fresh water in a cup, face towel (optional), mouthwash, and straw. Swabs for care for unconscious resident.

Name _____
Passed _____ Needs More Practice _____

The Conscious Resident With Their Own Teeth

____ 1. Assemble the equipment - check label for correct name.

____ 2. Wash your hands.

____ 3. Provide privacy for the resident.

____ 4. Inform resident what you will be doing.

____ 5. Ask resident how much he/she can do for themselves.

____ 6. Position towel to protect resident's clothing, sheets, etc.; or if resident is able, assist him/her to the bathroom.

____ 7. If facility policy requires, mix a half cup of water with half cup of mouthwash.

____ 8. Have the resident rinse his/her mouth with the mouthwash.

____ 9. Instruct the resident to expectorate the mouthwash into the sink or emesis basin you have positioned under the resident's chin.

____ 10. Dampen the toothbrush and assist resident to put toothpaste on the dampened toothbrush.

____ 11. If a resident is able, have him/her brush own teeth, if he/she can't, brush teeth for him/her. Use appropriate circular motions.

____ 12. Have the resident rinse the toothpaste out of his/her mouth using the mouthwash or fresh water.

____ 13. Make the resident comfortable/safe.

____ 14. Clean equipment and put it away. Wash your hands.

Denture Care

____ 1. Assemble equipment.

____ 2. Wash hands.

Skills Checklist #13 continued

____ 3. Provide the resident with privacy and explain what you will be doing.

____ 4. Prepare an emesis basin lined with tissue or a denture cup filled with water for placement of dentures.

____ 5. Ask the resident to remove the dentures and place in emesis basin or denture cup. Take to the sink and line sink with paper towels.

____ 6. If appropriate, fill denture cup with cool water and denture tablet and soak.

____ 7. Apply toothpaste or denture cleanser with dentures held securely in hand. Brush until dentures are clean.

____ 8. Rinse dentures thoroughly under cool running water.

____ 9. Have resident rinse mouth with mouthwash and brush any permanent teeth he/she may have. (see previous procedure).

____ 10. Keeping dentures moist, have resident replace in mouth.

____ 11. Clean equipment and put away, wash your hands.

Mouth Care for the Unconscious Resident

____ 1. Assemble the equipment and wash your hands.

____ 2. Provide privacy, tell the resident what you are going to do.

____ 3. Stand at bedside and turn the resident's head to the side facing you.

____ 4. Position towels under resident's head and face.

____ 5. Position emesis basin on towel under resident's chin.

____ 6. Open resident's mouth and hold tongue in place with tongue depressor.

____ 7. Wipe the resident's entire mouth with prepared packaged swabs, or applicators moistened with mouthwash. Clean tongue, inside cheeks and lips. Rinse with swabs dipped in clean water.

____ 8. Dry resident's face with towel and apply lubricant to resident's lips.

____ 9. Make resident comfortable, clean and store equipment.

____ 10. Wash hands and report any unusual observations.

Instructor's Signature_____Date_____

NURSE AIDE
Unit III

Skills Checklist #14
Partial Bath

Equipment: Soap, soapdish, washcloth, washbasin, bath thermometer if available, face and bath towels, clean gown, nail file.

Name _____
Passed _____ Needs More Practice _____

____ 1. Assemble the equipment and linen.

____ 2. Wash your hands.

____ 3. Provide privacy and tell the resident what you are going to do.

____ 4. Offer bedpan or urinal before you begin.

____ 5. Raise bed to high position.

____ 6. Place bath blanket over top linen.

____ 7. Fanfold the top linen to the foot of the bed without exposing resident.

____ 8. Position resident comfortably, flat if resident can tolerate.

____ 9. Remove resident's gown and jewelry; place gown with dirty linen, place jewelry in resident's bedside stand.

____ 10. Fill washbasin two-thirds full with 105-115°F.(36.1°C.) water. If available, use a thermometer to check.

____ 11. Help resident move to side of bed near aide. Use good body mechanics.

____ 12. Place towel across resident's chest. Make a mitten with the washcloth and wash resident's face first; dry face well by patting.

____ 13. Place towel under resident's far arm to protect bed, wash hand and axilla. Rinse and dry well.

____ 14. Repeat procedure for resident's hand, axilla near aide.

____ 15. Wash and pat dry areas where body folds and creases exist (e.g., under breasts, abdominal folds).

(Turn Page)

____ 16. Offer the resident a soapy cloth and ask him/her to wash genitals. If they are unable to do this, then you should do the genitals, washing with warm soapy water. Rinse and dry thoroughly. (Male: Cleanse penis by pushing back foreskin, gently washing penis, scrotum and anus. Women: Gently separate labia. Wash down one side and the other [front to back].) (See perineal care skills checklist.)

____ 17. Turn resident to side. Wash rectal area with warm water, rinse, pat dry. (Wash from perineal area toward rectum.)

____ 18. Empty, rinse, clean and store equipment Place dirty linen in bag.

____ 19. Assist the resident to dress. Comb hair.

____ 20. Make resident comfortable.

____ 21. Wash hands and report any observations to supervisor.

Comments:

Instructor's Signature_____ Date _____

NURSE AIDE
Unit III

Skills Checklist #15
Complete Bed Bath

Equipment: Soap, soapdish, washcloth, washbasin, bath thermometer if available, face and bath towels, clean gown, nail file, lotion.

Name _____
Passed _____ Needs More Practice _____

____ 1. Assemble the equipment.

____ 2. Wash your hands.

____ 3. Provide privacy and tell the resident what you are going to do.

____ 4. Offer bedpan or urinal before you begin.

____ 5. Assist with oral hygiene-see skills checklist.

____ 6. Raise bed to high position; loosen all linen and let hang loosely.

____ 7. Remove spread and blanket, fold over the back of the chair.

____ 8. Place bath blanket over top sheet and then remove top sheet without exposing resident; place dirty sheet in laundry bag or appropriate place.

____ 9. Position resident comfortably, in a flat position if resident can tolerate.

____ 10. Remove resident's gown and jewelry; place gown with dirty linen, place jewelry in resident's bedside stand.

____ 11. Fill washbasin two-thirds full with 105-115°F.(36.1°C.) water. If available, use a thermometer to check.

____ 12. Help resident move to side of bed near aide. Use good body mechanics.

____ 13. Place towel across resident's chest. Make a mitten with the washcloth and wash resident's face first; dry face well by patting.

____ 14. Place towel under resident's arm to protect bed, wash shoulders, axilla and arm. Rinse and dry well.

____ 15. Place resident's hand in water and wash. Clean fingernails.

____ 16. Wash other axilla and hand the same way.

____ 17. Place town across resident's chest. Fold bath blanket down. Wash neck and chest. Dry thoroughly. Examine female resident's breast.

Skills Checklist #15 continued

____ 18. Fold bath blanket down to pubic area and wash resident's abdomen. Dry well.

____ 19. Empty dirty water. Refill basin with water. Check water temperature.

____ 20. Place towel under one of resident's legs, wash and dry well.

____ 21. Place foot in basin and wash. Dry all creases and between the toes well.

____ 22. Do the other leg.

____ 23. Turn resident on his/her side.

____ 24. Place towel to protect bed and wash, rinse, and dry the resident's back of neck, back and buttock.

____ 25. Give the resident a back run with warmed lotion. Back rub should be for about a minute and one-half.

____ 26. Turn resident on his/her back, offer the resident a soapy cloth and ask him/her to wash genitals. If they are unable to do this, then you should do the genitals, washing with warm soapy water. Rinse and dry thoroughly. (Male: Cleanse penis by pushing back foreskin, gently washing penis, scrotum and anus. Women: Gently separate labia. Wash down one side and the other [front to back].)

____ 27. Assist the resident to dress. Comb hair.

____ 28. Position resident comfortably. Clean equipment and put it away.

____ 29. Wash hands and report any observations to supervisor.

Comments:

Instructor's Signature_____ Date _____

NURSE AIDE
Unit III

Skills Checklist # 16
Providing Perineal Care

Equipment: Basin of warm water, soap, towel and washcloth, if available peribottle with warm water.

Name _____
Passed _____ Needs More Practice _____

____ 1. Wash hands - follow CDC precautions. (May use gloves.)

____ 2. Provide privacy and explain procedure to resident

____ 3. Remove soiled pads, clothing, linen.

____ 4. Men-cleanse penis by pushing back foreskin-gently wash around penis and scrotom.

____ 5. Women-gently separate labia-wash down one side then the other. (Wash from front to back)

____ 6. Wash buttocks and upper thighs.

____ 7. Rinse thoroughly. Optional-position resident on bedpan and using peribottle rinse perineal area by squeezing water from bottle over perineal area.

____ 8. Dry thoroughly.

____ 9. Dress in clean clothing, make sure linen is clean and dry.

____ 10. Make resident comfortable.

____ 11. Clean and return equipment.

____ 12. Wash hands and report any unusual findings to supervisor.

Comments:

Instructor's Signature _____ Date _____

Skill Checklist #17
Whirlpool Bath

Equipment: Towels, washcloths, soap, transfer chair, materials to clean tub.

Name_____
Passed_____ Needs More Practice_____

____ 1. Check with nurse to see which residents get whirlpool baths, and for which residents the whirlpool can be turned on.

____ 2. Assemble equipment and prepare the whirlpool.

____ 3. Wash hands, Check temperature of whirlpool (100-105°F).

____ 4. Explain to the resident what you are going to do and the purpose of the whirlpool.

____ 5. Fill tub with water above the aerorator opening.

____ 6. Take resident to whirlpool, position in transfer chair.

____ 7. Fasten seatbelt securely, instruct resident on how he/she can help.

____ 8. Check and position elbows and feet.

____ 9. Slowly raise the resident.

____ 10. Slowly lower the resident into the tub, check resident's reaction to water temperature before completely immersing.

____ 11. Once resident is lowered, if ordered turn the whirlpool on.

____ 12. Assist the resident with washing, as needed.

____ 13. Begin to drain water from the whirlpool.

____ 14. Put towel or bath blanket over the resident to keep from chilling.

____ 15. Tell resident what you are doing and slowly raise out of whirlpool.

____ 16. Position resident. Dry well and assist with dressing. Comb hair.

____ 17. Clean whirlpool.

____ 18. Return resident to room or where he/she is to be at the time.

(Turn Page)

Skills Checklist #17 continued

____ 19. Wash hands.

____ 20. Report any unusual observations to supervisor.

Comments:

Instructor's Signature _____ Date_____

NURSE AIDE
Unit III

Skills Checklist #18
Tub Baths and or Shower

Equipment: Bath towels, thermometer if available, soap, washcloth, resident's clean clothing, disinfectant for cleaning tub.

Name _____
Passed _____ Needs More Practice _____

____ 1. Assemble equipment.

____ 2. Wash hands.

____ 3. Tell resident you will be helping his/her with tub bath/shower.

____ 4. Insure privacy.

____ 5. Help resident out of bed, assist with putting on robe and slippers take him/her to the tub room.

____ 6. Check for possible safety hazards in bathroom.

____ 7. Clean tub with disinfectant solution.

____ 8. Fill tub one-half full of water at 105-115°F. (40.5° C.). Test water with a thermometer, if available. For shower, regulate and test water temperature.

____ 9. Place a towel in the bathtub for resident to sit on.

____ 10. Place a towel on the floor where the resident will step out of the tub/shower. This will prevent slipping.

____ 11. Assist resident to get undressed and into the bathtub/shower.

____ 12. If using shower chair, lock brakes.

____ 13. Help the resident to wash himself/herself, if needed.

____ 14. Put a towel on the chair.

____ 15. Help resident out of the tub/shower, being careful he/she doesn't slip. Sit him/her on the chair.

____ 16. Dry resident well. Help him/her dress. Comb hair.

____ 17. Return resident to room or wherever he/she is to go at the time.

(Turn Page)

Skills Checklist #18 continued

____ 18. Clean tub and bathroom area. Remove all soiled linen.

____ 19. Wash your hands.

Comments:

Instructor's Signature_____ Date_____

NURSE AIDE
Unit III

Skill Checklist #19
Back Rub

Equipment: Bath blanket, bath towel, lotion.

Name _____
Passed _____ Needs More Practice _____

____ 1. Assemble equipment.

____ 2. Wash hands.

____ 3. Provide privacy and tell resident what you are going to do.

____ 4. Raise bed.

____ 5. Position resident on side or abdomen.

____ 6. Place the bath blanket over the top covers and fan fold the covers to the back of the bed without exposing the resident.

____ 7. Expose the back, shoulders and upper arms and buttocks. Cover the rest of the body with a bath blanket.

____ 8. Warm lotion by holding under warm water or warming it with the your palms.

____ 9. Place the towel on the bed along the back.

____ 10. Apply lotion to entire back with the palms of your hands.

____ 11. Exert firm pressure upward, buttocks to shoulder, and relax pressure shoulders to buttocks.

____ 12. Use circular motions with palms over bony prominence - especially shoulders/scapula and coccyx. Repeat #11 and #12 for 1.5 to 3 minutes.

____ 13. Wipe off excess lotion with a towel.

____ 14. Cover the resident. Remove the towel and bath blanket. Put equipment away.

____ 15. Make sure the resident is comfortable.

____ 16. Place signal light within resident reach.

(Turn Page)

Skills Checklist #19 continued

____ 17. Lower the bed to its lowest position.

____ 18. Wash hands and report any observations to supervisor.

Comments:

Instructor's Signature_____Date_____

Skills Checklist #20
Shampooing a Resident's Hair

Equipment: Shampoo, washcloth, towels, - optional cotton for ears, pitcher, blow dryer.

Name _____
Passed _____ Needs More Practice _____

____ 1. Check the schedule to see when/if resident's hair is to be shampooed-frequently this is done with the shower.

____ 2. Assemble the equipment. Check to see if resident has a special shampoo.

____ 3. Wash hands.

____ 4. Explain to the resident what you are going to do.

____ 5. Have resident cover eyes with a dry washcloth. If resident is unable to do this, aide holds washcloth over eyes with one hand. Protect the ears so water does not run in during shampoo. (Using cotton or hand over ears)

____ 6. Wet the hair. Apply shampoo.

____ 7. Wash hair and massage the scalp with fingertips or if resident is able have resident do this.

____ 8. Rinse hair thoroughly.

____ 9. Dry thoroughly by rubbing hair and scalp with towel.

____ 10. If resident is in shower or whirlpool, finish bath.

____ 11. Dress resident, comb hair according to proper procedure.

____ 12. If available, blow dry hair.

____ 13. Remove equipment. Clean bathroom.

____ 14. Wash hands.

____ 15. Report anything unusual to supervisor.

Comments:

Instructor's Signature_____ Date _____

NURSE AIDE
Unit III

Skills Checklist #21
Nail Care

Equipment: Basin of warm soapy water, nail file, clippers, emery board, towel.

Name _____
Passed _____ Needs More Practice _____

Fingernails

____ 1. Check with supervisor to determine what type of nail care aide can do for resident. (Aides are not to do nail care on residents who are diabetic or have a circulatory problem)

____ 2. Explain to the resident what you are going to do.

____ 3. Assemble equipment.

____ 4. Wash hands.

____ 5. Do nails following bath or soak hands/feet in warm water for a few minutes before cleaning/trimming.

____ 6. Place hand on which nails are to be trimmed on a towel on a table.

____ 7. Push back cuticle.

____ 8. Gently remove dirt from under the nails with a file.

____ 9. Using a clipper or nail file, shape fingernails. (moon shaped)

____ 10. Be careful not to nick skin, cuticle or to file too close to the cuticle on the side of the nail.

____ 11. Do the other hand in the same manner.

Toenails Follow steps 1-5 for fingernail care.

____ 12. Position foot on which nail care is to be done on a towel.

____ 13. Clean nails and trim straight across with a toenail clipper.

____ 14. Put on resident's shoes and stockings.

____ 15. Put equipment away and clean area.

____ 16. Wash hands and report any problems/observations to supervisor.

Comments:

Instructor's Signature _____ Date _____

NURSE AIDE
Unit III

Skills Checklist #22
Grooming - Dressing/Undressing Resident

Name_____
Passed_____ Needs More Practice_____

____ 1. Wash hands.

____ 2. Explain to the resident what you are going to do.

____ 3. Determine what the resident can do for self.

____ 4. Provide privacy.

____ 5. Choose appropriate clothing with resident's preference considered.

6. Dress resident.

____ a. Remove night clothes.

____ b. Remove one arm of a shirt or blouse at a time.

____ c. If paralyzed on one side, dress the affected arm or leg first.

____ d. Remove clothing from affected arm or leg last.

____ e. Pull clothing off being gentle and with even motions (no jerking).

____ f. Put sheet/dress/clothing on affected arm or leg first.

____ g. Button, tie, secure clothing appropriately for resident.

____ h. Be sure clothing is on appropriately - not backwards, etc.

7. Groom hair appropriately.

____ a. Ask resident's preference for how to fix hair.

____ b. Brush, comb hair starting with ends going toward scalp.

____ 8. Be sure resident is comfortable.

____ 9. Wash hands.

Comments:

Instructor's Signature _____ Date _____

NURSE AIDE
Unit III

Skills Checklist #23
Shaving a Resident With An Electric Razor

Equipment: Electric razor, towel, washcloth, soap, basin of warm water, pre-shave lotion and after shave lotion (if available), mirror

Name _____
Passed _____ Needs More Practice _____

____ 1. Assemble your equipment on bedside table.

____ 2. Wash your hands.

____ 3. Explain to resident what you are going to do.

____ 4. Screen resident for privacy.

____ 5. Make sure there is adequate lighting.

____ 6. Raise the head of the bed or assist the resident to the chair.

____ 7. Wash face and neck with soap and water and rinse and towel dry so face is clean and facial oils are removed before starting.

____ 8. If resident has dentures, make sure they are in.

____ 9. Apply pre-shave lotion, using care not to get any in eyes or mouth of resident. Include the neck.

____ 10. Plug razor into 110 volt receptacle.

____ 11. With the fingers of one hand, hold the skin tight as you shave in a circular motion in the direction the hairs grow. Start under the sideburns and work over to the cheeks. Continue carefully over the chin. Work upward on the neck under the chin. Areas under the nose and around the lips are sensitive. Take special care in these areas.

____ 12. When you are finished, apply after shave lotion if available.

____ 13. Pull privacy curtain open.

____ 14. Lower the head of the bed and make the resident comfortable. Make sure call light is within reach and siderails are up in indicated.

____ 15. Clean equipment and put in proper place. Clean razor by removing the head and using a soft brush to remove the whiskers. Wipe off head with alcohol prep. Put razor back in case. NEVER USE A RESIDENT'S OWN RAZOR FOR ANYONE ELSE. THIS IS THEIR PRIVATE PROPERTY.

(Turn Page)

____ 16. Wash your hands.

____ 17. Report any unusual observations to the nurse.

SPECIAL INSTRUCTIONS:

1. Do not use pre-shave or after shave if resident's skin is irritated, red, or if open areas are present.

2. Report dull blades, frayed cords, and poor functioning equipment to the nurse.

3. Always encourage the resident to do as much of the procedure that he is able to do and assist as needed.

Comments:

Instructor's Signature _____ Date _____

NURSE AIDE
Unit III

Skills Checklist #24
Giving a Male Resident the Urinal

Equipment: Urinal, urinal cover, water or wet cloth and towel to wash hands.

Name _____
Passed _____ Needs More Practice _____

____ 1. Assemble the equipment.

____ 2. Wash your hands.

____ 3. Provide privacy. Explain to the resident what you are going to do.

____ 4. Place or assist the resident to place the urinal so urine will flow into the urinal.

____ 5. Place the signal cord within easy reach of the resident and tell him to push the button when he is finished.

____ 6. Wash your hands and leave the room; be alert for the signal light.

____ 7. When resident signals or after a short time, return to the room.

____ 8. Remove urinal, cover and take it to the bathroom.

____ 9. Check urine for unusual appearance, if resident is on intake-output, measure the urine.

____ 10. Empty urine into toilet. Rinse urinal with clean water.

____ 11. Return clean urinal to resident's bedside.

____ 12. Assist the resident to wash hands.

____ 13. Wash your hands.

____ 14. Record output if required, report any unusual observations to your supervisor.

Comments:

Instructor's Signature_____ Date _____

NURSE AIDE
Unit III

Skills Checklist #25
Assisting the Resident with A Bedpan

Equipment: Bedpan, bedpan cover, tissue, water or wet washcloth, towel.

Name _____
Passed _____ Needs More Practice _____

BEDPAN

____ 1. Assemble equipment.

____ 2. Wash hands.

____ 3. Provide privacy. Explain what you are going to do.

____ 4. If bedpan is metal, warm the bedpan by running warm water over. Dry the outside of the bed pan.

____ 5. Lower siderails, fold back the top sheets if they are in the way.

____ 6. Raise the resident's gown.

____ 7. Ask the resident to bend his/her knees; put feel flat on the mattress; and raise hips by pressing feet down on the bed. If necessary, help the resident raise his/her buttocks by slipping your hand under the lower part of the back. Place the bedpan in position under the buttocks.

____ 8. If resident unable to lift buttocks; then turn resident to his/her side away from you. Position bedpan under buttock. Turn resident toward you, bedpan will be in correct position.

____ 9. Replace covers over resident.

____ 10. Raise the backrest and knees,(if allowed). Resident should be in as much of a sitting position as possible.

____ 11. Place toilet tissue and signal cord where resident can easily reach them. Ask resident to signal when finished.

____ 12. Place side rails in up position if resident requires.

____ 13. Wash hands and leave room to give resident privacy. Watch for the signal light.

____ 14. After a short time or when resident signals, return to room. Help the resident to raise hips and remove bedpan.

____ 15. Cover the bedpan immediately.

(Turn page)

Skills Checklist #25 continued

____ 16. If resident unable to clean self, help him/her by turning resident on side and clean with toilet tissue or damp cloth.

____ 17. Take bedpan to resident's bathroom. If resident is on intake, measure urine. Check feces, urine for unusual appearance.

____ 18. Empty the bedpan and follow the facility's procedure for cleaning the bedpan.

____ 19. Return bedpan to bedside stand.

____ 20. Help resident wash his/her hands, and position comfortably.

____ 21. Wash hands. Report any unusual observations to the supervisor.

USING THE COMMODE

____ 22. Get help if needed. Wash hands.

____ 23. Position commode beside bedside, lock wheels.

____ 24. Provide privacy. Explain to resident what you are going to do.

____ 25. Transfer resident from bed following correct transfer procedure.

____ 26. If ordered and needed, apply restraints. Never leave a confused or weak resident alone on the commode.

____ 27. If resident is alert, leave room, place call button within easy reach of the resident and check resident frequently.

____ 28. When resident is finished, help him/her clean himself/herself if necessary and then return to bed.

FOLLOW STEPS 17 THROUGH 21 OF THE ABOVE PROCEDURE

Comments:

Instructor's Signature_____ Date _____

NURSE AIDE
Unit IV

Skills Checklist #26
Preparing a Resident for a Meal and Feeding a Resident

Equipment: Washcloth for washing resident's hands, napkin, silverware, straw,

Name _____
Passed _____ Needs More Practice _____

Preparing Resident for Meal

____ 1. Tell the resident you will be helping him/her to eat.

____ 2. Offer bedpan/assist to bathroom, if able.

____ 3. Wash hands.

____ 4. Help resident wash hands. Check nails.

____ 5. Remove unpleasant odors/objects.

____ 6. Position resident comfortably at the table; or if eating in bed, with head elevated. If resident in chair, be sure robe and slippers are on.

____ 7. Check to make sure the resident has the correct diet.

____ 8. Arrange food on tray.

____ 9. Open cartons - cut meat, if necessary.

Feeding the Resident

____ 10. Make yourself comfortable. If you sit, you and the resident will be more relaxed. Set facing resident.

____ 11. Position napkin to protect resident's clothing. Encourage resident to assist as much as he/she is able.

____ 12. Season food according to resident's preference.

____ 13. Ask resident what he/she would like to eat first.

____ 14. Fill spoon/fork only half-full.

____ 15. Put the food in the side of the resident's mouth, using tip of spoon not side.

____ 16. Alternate liquids and solids.

(Turn page)

Skills Checklist #26 continued

____ 17. Use a straw for liquids, if possible.

____ 18. Feed resident slowly. Allow him/her to chew and swallow before giving more food.

____ 19. Assist resident in washing face and hands. Make him/her comfortable.

____ 20. If resident is on intake/output, record intake.

____ 21. Wash hands. Report anything unusual to supervisor. e.g. how much was eaten or comments concerning meal.

Comments:

Instructor's Signature_____ Date _____

NURSE AIDE
Unit V

Skills Checklist #27
Vital Signs - TPR

Equipment: Thermometer, paper towel to wipe thermometer, thermometer container watch with second hand, probes and stand if using electronic therm.

Name_____
Passed _____ Needs More Practice _____

A. Oral Temperature with Mercury Thermometer

____ 1. Assemble equipment.

____ 2. Wash hands.

____ 3. Tell the resident what you are going to do.

____ 4. Ask resident if he/she has had hot or cold fluids recently, or been smoking. If he/she has, wait ten minutes to take temperature.

____ 5. The resident should be in bed or sitting in a chair when temperature is taken.

____ 6. Take thermometer out of container, rinse thermometer with cool water, check for chips or cracks.

____ 7. Shake down the mercury. Apply thermometer cover.

____ 8. Gently place the bulb end of the thermometer under the resident's tongue. Ask the resident to keep mouth and lips closed.

____ 9. Leave the thermometer in the resident's mouth for 3-8 minutes. You may be taking resident's pulse and respirations while waiting.

____ 10. Take the thermometer out of the resident's mouth, remove cover, wipe with kleenex from stem to bulb end.

____ 11. Read the thermometer accurately. Must be exact.

____ 12. Record.

____ 13. Shake down the mercury, wash with soap and cool water. Replace in proper container filled with proper disinfectant solution.

____ 14. Make the resident comfortable.

____ 15. Wash your hands. Report any temperature above 100°F. or 37.8°C. to supervisor.

(Turn Page)

B. Rectal Temperatures with Mercury Thermometer

____ 16. Assemble equipment.

____ 17. Wash hands and explain to the resident what you are going to do.

____ 18. Provide privacy. Lower bed. Turn resident onto his/her side. Inspect to see that no fecal material is obstructing rectum.

____ 19. Remove thermometer from container. Hold only by stem. Rinse with cool water. Inspect for cracks or chips.

____ 20. Shake down thermometer. Put a small amount of lubricating jelly on tissue and lubricate bulb of thermometer.

____ 21. Position your left hand on resident's back to prevent resident from rolling back, and with other hand raise the upper buttock until you can see the anus. Gently insert bulb of the thermometer for 1 inch.

____ 22. Hold the thermometer in place for 3-5 minutes, while helping resident maintain side position with your left hand on resident's back.

____ 23. Remove thermometer from rectum by the stem. Wipe with a tissue from stem to bulb.

____ 24. Read the thermometer and record.

____ 25. Make the resident comfortable.

____ 26. Wash your hands and immediately report a temperature above 101°F. or 38.3°C. to your supervisor.

C. Oral Temperature with Electronic Thermometer

____ 1. Assemble equipment.

____ 2. Wash your hands.

____ 3. Provide privacy and explain to resident what you will be doing.

____ 4. Check to make sure the probe connector is properly placed in receptacle.

____ 5. Remove probe from stored position and insert into the sheath or probe cover.

____ 6. Insert the covered probe into the resident's mouth slowly until the metal tip is at the base of the tongue to the back of the resident's mouth.

(Turn Page)

____ 7. Hold the probe in the resident's mouth. It is much heavier than a glass thermometer.

____ 8. Wait about 15 seconds for the buzzer to ring, then remove the probe from the resident's mouth.

____ 9. Read and record the temperature. Must be exact.

____ 10. Discard the used probe cover/sheath. Do not touch while removing.

____ 11. Return the probe to its stored position, and store in charging stand.

____ 12. Make the resident comfortable. Wash your hands and report any temperature above 100°F. or 37.8°C. to supervisor.

D. Obtaining a Rectal Temperature with an Electronic Thermometer

____ 13. Assemble equipment.

____ 14. Provide privacy, and explain to the resident what you are going to do.

____ 15. Check to be sure the rectal probe is seated properly in the receptacle.

____ 16. Remove the probe from its stored position and insert it into a probe cover or sheath.

____ 17. Turn resident on side, secure his/her position by positioning one hand on the back. Using the other hand insert covered probe into the rectum one-half inch and hold until buzzer rings.

____ 18. Remove probe from rectum. Record temperature.

____ 19. Discard the used probe cover, do not touch.

____ 20. Return probe to correct position and store thermometer in charging stand.

____ 21. Make the resident comfortable. Wash your hands.

____ 22. Report a temperature above 101°F. or 38.3°C. to supervisor.

E. Measuring the Resident's Radial Pulse

____ 1. This is usually done at the same time that you take the resident's temperature and respirations.

(Turn Page)

____ 2. Assemble equipment. Wash hands.

____ 3. Tell the resident what you are going to do. Position resident so his/her arm and hand are resting comfortably.

____ 4. Find the pulse by placing the tips of your middle three fingers on the palm side of the resident's wrist over the radial artery.

____ 5. After locating the pulse, note the rhythm and if the beat is steady or irregular.

____ 6. Count for one full minute or sixty seconds.

____ 7. Calculate accurate pulse within 3 beats.

____ 8. Record the pulse on the TPR sheet.

____ 9. Make the resident comfortable. Wash your hands.

____ 10. Report any pulse rate under 60 or over 90 to the supervisor. Also report unusual beat.

F. <u>Measuring the Resident's Respirations</u>

____ 1. Usually done when obtaining temperature and pulse.

____ 2. Continue holding the resident's wrist after obtaining the pulse.

____ 3. If you cannot see the rise and fall of the resident's chest, fold the resident's arm across the chest, then you can feel the respirations.

____ 4. Count each rise and fall of the chest as one respiration.

____ 5. Count the respirations for one full minute or 60 seconds.

____ 6. Calculate accurate respiratory rate within 2 respirations.

____ 7. Record the respirations on the TPR sheet.

____ 8. Make the resident comfortable. Wash your hands.

____ 9. Report any unusual rhythm, sound or if respirations are less then 14 or more than 28 to your supervisor.

Comments:

Instructor's Signature_____ Date _____

NURSE AIDE
Unit V

Skills Checklist #28
Measuring Blood Pressure

Equipment: Sphygmomanometer (blood pressure cuff), stethoscope, antiseptic pad, blood pressure board, book or form used in your facility

Name_____
Passed _____ Needs More Practice _____

____ 1. Wash your hands.

____ 2. Assemble equipment.

____ 3. Wipe the earplugs of the stethoscope with the antiseptic pads.

____ 4. Tell the resident what you will be doing.

____ 5. Have the resident resting quietly. He/she should be either lying down or sitting in a chair.

____ 6. The resident's arm should be bare up to the shoulder or the resident's sleeve should be well above the elbow.

____ 7. The resident's arm from the elbow down should be resting fully extended on the bed. Or it might be resting on the arm of the chair, or your hip, well-supported, with the palm upward.

____ 8. Unroll the cuff and loosen the valve on the bulb. Then squeeze the compression bag to deflate it completely.

____ 9. Wrap the cuff around the resident's arm 1/2 inch above the elbow snugly and smoothly. But do not wrap it so tightly that the resident is uncomfortable from the pressure.

____ 10. Leave the arm area clear where you will place the bell or diaphragm of the stethoscope.

____ 11. Be sure the manometer is in position so you can read the numbers easily. If using mercury sphygmomanometer, it should be at eye level.

____ 12. With your fingertips, find the resident's brachial pulse at the inner aspect of the arm above the elbow (brachial artery). This is where you will place the diaphragm or bell of the stethoscope. The diaphragm should be held firmly against the resident's skin, but it should not touch the cuff of the apparatus.

____ 13. Put the earplugs of the stethoscope into your ears.

(Turn Page)

____ 14. Tighten the thumbscrew of the valve to close it. Turn it clockwise. Be careful not to turn it too tightly. If you do, you will have trouble opening it.

____ 15. Hold the stethoscope in place. Inflate the cuff until the dial points to 170 or determine inflation by radial palpation.

____ 16. Open the valve counter-clockwise. This allows the air to escape.

____ 17. Note the calibration (number) that the pointer passes as you hear the first sound. This point indicates the systolic pressure (or the top number).

____ 18. Continuing releasing the air from the cuff. When the sounds change to a softer or muffled and faster thud or disappear, note the calibration. This is the diastolic pressure (or bottom number).

____ 19. Deflate the cuff completely. Remove it from the resident's arm.

____ 20. Measure accurately - must be within 4 mm.

____ 21. Record your reading on the blood pressure board, blood pressure book, or form used in your institution.

____ 22. After using the blood pressure cuff, roll it up over the manometer and replace it in the case.

____ 23. Wipe the earplugs of the stethoscope again with an antiseptic swab. Put the stethoscope back in it proper place.

____ 24. Make the resident comfortable.

____ 25. Lower the bed to a position of safety for the resident.

____ 26. Wash your hands.

____ 27. Report to your supervisor that you measure the patient's blood pressure, the time that you measured the blood pressure, and your observations of anything unusual.

Comments:

Instructor's Signature _____ Date _____

NURSE AIDE
Unit V

Skills Checklist #29
Obtaining Resident's Height and Weight

Equipment: Upright scale or scale used in your facility

Name _____
Passed _____ Needs More Practice _____

____ 1. Wash hands

____ 2. Transport/walk resident to scale or bring scale to bedside.

____ 3. Place weights to extreme left.

____ 4. Help resident remove shoes. Position on scale--facing scale.

____ 5. Move weights to estimated weight.

____ 6. Balance weights until bar hangs halfway between.

____ 7. Add the two figures - record accurately in appropriate place - must be exact.

____ 8. Have resident turn and face you.

____ 9. Lower height bar to top of resident's head.

____ 10. Calculate height accurately - record in appropriate place.

____ 11. Return resident to room/bed - replace equipment

____ 12. Report weight variations of 2-5 pounds to supervisor.

Comments:

Instructor's Signature _____ Date _____

NURSE AIDE
Unit V

Skills Checklist #30
Measuring Intake and Output

Equipment: Intake chart, intake/output sheet, urinal or bedpan, measured graduate.

Name_____
Passed _____ Needs More Practice _____

Intake

____ 1. Explain to the resident that the amount of fluids he/she drinks is being recorded, and ask him/her to help if able.

____ 2. Observe all fluids the resident drinks during and between meals. This is done throughout the entire period in which you are working.

____ 3. Calculate amount of liquids resident drinks during meal within 20cc.

____ 4. Check the intake chart for standard amounts. Make sure the resident has consumed everything being recorded.

____ 5. Record everything consumed during the shift as it is consumed, be sure and add up the amounts after meals. These amounts should be recorded in c.c's.

____ 6. At the end of the shift, total everything consumed during the shift and mark total in the designated space on intake-output sheet.

Output

____ 7. Explain to the resident that you will be measuring the amount of urine he/she is putting out, and explain he/she must use urinal or bedpan. A special bedpan should be used if resident is also having a bowel movement.

____ 8. Instruct the resident not to put toilet tissue in the bedpan.

____ 9. After the resident has urinated, pour urine from urinal or bedpan into the graduate for measuring urine.

____ 10. Read the amount of urine by using the graduated lines on the container - must be within 20cc.

____ 11. Observe urine for unusual appearance. Report if noted.

____ 12. Empty urinal or bedpan, rinse and return to proper place. Take the toilet tissue from wastebasket and put in stool and flush stool.

____ 13. Wash hands.

(Turn Page)

Skills Checklist # 30 continued

____ 14. Record the amount of the output on the intake/output sheet in c.c's.

____ 15. Total the entire amount of output at the end of the shift when you total the input, and report/record as required by your facility.

Comments:

Instructor's Signature_____Date_____

Skills Checklist #31
Obtaining a Routine Urine Sample

Equipment: Bedpan, urinal, graduate, specimen container with lid and label, laboratory requisition (as per facility)

Name _____
Passed _____ Needs More Practice _____

____ 1. Assemble equipment.

____ 2. Wash hands.

____ 3. Provide the resident with privacy.

____ 4. Explain the procedure to the resident, ask him/her not to put toilet tissue in bedpan.

____ 5. Have the resident urinate into clean bedpan or urinal.

____ 6. Prepare the label by filling in all required information. Record the date and time.

____ 7. Take the bedpan to resident's bathroom.

____ 8. Pour the urine into a clean graduated container without bedan touching graduate.

____ 9. If resident is on output, measure and record amount. Pour the urine from graduate into specimen bottle without graduate touching the specimen bottle.

____ 10. Put the lid on the bottle and put the correct label on the specimen bottle.

____ 11. Pour the extra urine into stool.

____ 12. Clean and rinse graduate. Return to proper place.

____ 13. Clean bedpan or urinal and return to proper place.

____ 14. Place specimen in proper place for pick up or take to lab. (Facility policy)

____ 15. Wash hands and report to the nursing supervisor. Maintain a clean technique during procedure.

Comments:

Instructor's Signature_____Date_____

Skills Checklist #32
Giving Daily Catheter Care

Equipment: Disposable catheter care kit if used by your facility or materials listed in facility catheter care procedure. Soap and water, wash cloth, towel, disposable gloves (if used in your facility). graduate for emptying bag.

Name_____
Passed _____ Needs More Practice _____

Catheter Care

____ 1. Assemble equipment.

____ 2. Wash your hands.

____ 3. Tell the resident what you are going to do.

____ 4. Insure privacy and warmth.

____ 5. Put on disposable gloves being careful not to contaminate gloves before care.

____ 6. Cleanse area around meatus with cleansing solution. Gently separate labia on female, wash from front to back. Gently pull back foreskin on male, replace after cleansing.

____ 7. Cleanse four inches of the tube closest to the resident.

____ 8. Follow the facility's routine for applying antiseptic ointment.

____ 9. Discard gloves. Clean and put equipment away.

____ 10. Wash your hands.

____ 11. Report to supervisor that care has been given and any unusual observations.

Emptying Drainage Bag

____ 12. Assemble equipment. Wash hands.

____ 13. Observe CDC precautions.

____ 14. Open drain and let urine run into graduate. Be sure you do not contaminate drain.

(Turn Page)

Skills Checklist #32 continued

____ 15. Measure/calculate amount within 20cc's.

____ 16. Wash hands and record on I & O sheet.

Comments:

Instructor's Signature_____ Date_____

Skills Checklist #33
Communication/Resident's Rights

Objective: To be used whenever student does return demonstrations.

Name_____
Passed _____ Needs More Practice _____

____ 1. Address resident by name when entering room.

____ 2. Introduce yourself by name.

____ 3. Explain all procedures to resident. Explain what you will be doing.

____ 4. Be sure resident understands by asking them to repeat.

____ 5. Be aware of condition of resident that might affect speech or comprehension.

____ 6. Listen attentively.

____ 7. Answer call light promptly in friendly manner.

____ 8. Make observations and reports to nurse effectively.

____ 9. Provide privacy. Do not expose during any procedure. Use screens/ pull curtains.

____ 10. Appropriately answers questions resident asks.

____ 11. Provide adequate time for resident to react. Do not rush. Maintain resident safety at all times.

____ 12. Ask resident if they need anything else when finished and tell resident when leaving. Leave call button within easy reach.

____ 13. Voice is friendly - smile appropriately.

____ 14. Report/record accurately.

Comments:

Instructor's Signature_____ Date_____

NURSE AIDE COURSE

Summary Sheet of Skills Checklists

Student's Name _____

Total Number of Hours Student Attended During the Course _____

Description: The following summary is a record of the nurse aide's level of achievement for each competency included in the 75 hour course. The date indicates when the nurse aide demonstrated this competency at this level:

4 - prepared to perform competency independently
3 - Prepared to perform competency with supervision/assistance
2 - Not prepared to perform competency
1 - No exposure - no clinical experience or knowledge in this area

Skills	Competency Level - Dates Achieved			
	4	3	2	1
1. Handwashing Technique				
2. Making Closed and Open Bed				
3. Making Occupied Bed				
4. Conscious/Unconscious Choking Victim				
5. Safely Applying Restraints				
6. Safely Using Mechanical Lifts				
7. Lifting/Moving a Resident in Bed				
8. Using a Gait (Transfer) Belt				
9. Transferring Resident from Bed to Chair				
10. Positioning Resident in Bed				
11. Ambulation				
12. Range of Motion				
13. Assisting with Oral Hygiene Needs				
A. Conscious Resident				
B. Denture Care				
C. Unconscious Resident				
14. Partial Bath				
15. Complete Bed Bath				

Skills	Competency Level - Dates Achieved 4	3	2	1
16. Providing Perineal Care				
17. Whirlpool Bath				
18. Tub Bath				
19. Back Rub				
20. Shampooing Hair				
21. Nail Care				
22. Grooming-Dressing/Undressing				
23. Shaving a Resident with an Electric Razor				
24. Giving Male Resident Urinal				
25. Assisting with Bedpan/Commode				
26. Preparing for Meal/Feeding				
27. Vital - TPR				
A. Mercury Thermometer--oral				
B. Mercury Thermometer--rectal				
C. Electronic Thermometer--oral				
D. Electronic Thermometer--rectal				
E. Pulse and Respiration				
28. Blood Pressure				
29. Obtain Height and Weight				
30. Intake/Output				
31. Routine Urine Sample				
32. Catheter Care/Emptying Drainage Bag				
33. Communications				

Signatures at end of Summary:

Instructor _____ Date _____

Student _____ Date _____

NURSE AIDE COURSE
CLINICAL EVALUATION

Purpose: This clinical evaluation is to be used when working with residents in long term care to assist the learner to recognize those things they do well and to identify those areas where they need to improve. Students are marked relative to how well they perform in each area. The possible score includes above average, average and needs improvement. The comment area is to allow students (on self evaluation) and instructors on their evaluations to describe what performances can be improved and how they can be improved.

Name_____ Date_____

Clinical Site_____ Hours Attended_____

PERSONAL CHARACTERISTICS

	Above Average	Average	Needs Improvement	Comments
PERSONAL APPEARANCE: Well groomed-neat in dress and appearance.				
DEPENDABILITY: Reports to work on time. Does not miss work. Completes work on time.				
COOPERATIVENESS: Assists others when needed. When asked does tasks promptly.				
ACCEPTANCE OF CRITICISM, SUGGESTIONS: Uses criticism and suggestions to improve.				
ABILITY TO LEARN: Follows directions, learns new skills and procedures within acceptable time.				
INITIATIVE: Sees what needs to be done does is without having to be told. Solves some problems on own.				
JUDGMENT: Makes good decisions, uses fairness and common sense. Seeks help when needed.				

Over

Clinical Evaluation Continued

	Above Average	Average	Needs Improve-ment	Comments
WORKS INDEPENDENTLY: Can work alone without supervision.				
QUALITY-QUANTITY OF WORK: Accurate, thorough, accomplishes what should be done.				

INTERPERSONAL RELATIONSHIPS WITH RESIDENT/PATIENTS

	Above Average	Average	Needs Improve-ment	Comments
RELATIONSHIP WITH RESIDENT: Is friendly, kind and under-standing.				
RESIDENT SAFETY: Uses medical asepsis, wipes spills up immediately concerned about resident safety.				
OBSERVATIONS/REPORTING: Makes appropriate observa-tions and reports them on timely basis.				

GENERAL SUMMARY OF CLINICAL EXPERIENCE

Instructor's Signature_____

Grade_____ Date_____